

Steven Geiringer, MD

11/21/2012

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IN THE DISTRICT COURT OF THE UNITED STATES  
FOR THE EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

JAROSLAW WASKOWSKI,

Plaintiff,

vs.

Civil Action

No. 11-CV-13036

HON. MARK A. GOLDSMITH

STATE FARM MUTUAL AUTOMOBILE  
INSURANCE COMPANY,

MAG. JUDGE HLUCHANIUK

Defendant,

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The Videotaped Deposition of  
STEVEN R. GEIRINGER, M.D.,  
Taken at 36301 Warren Road,  
Westland, Michigan,  
Commencing at 12:49 p.m.,  
Wednesday, November 21, 2012,  
Before Dale E. Rose, CSR-0087.

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1 APPEARANCES:

2

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8 Appearing on behalf of the Plaintiff

9

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16 Appearing on behalf of the Defendant

17

18 ALSO PRESENT:

19 MARC MEYERS, Videographer

20

21

22

23

24

25

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1 Westland, Michigan

2 Wednesday, November 21, 2012

3 About 12:49 p.m.

4 VIDEOGRAPHER: We are now on the  
5 record. This is the videotaped deposition of  
6 Dr. Steven Geiringer being taken in Westland,  
7 Michigan. Today is Wednesday, November 21, 2012,  
8 the time is now 12:49 PM.

9 And at this time will the attorneys  
10 please state your appearances for the record and  
11 the court reporter please swear in the doctor.

12 MR. TEMROWSKI: Lee Temrowski appearing  
13 on behalf of Mr. Waskowski.

14 MR. HEWSON: James Hewson appearing on  
15 behalf of State Farm.

16 STEVEN R. GEIRINGER, M.D.,  
17 having first been duly sworn, was examined and  
18 testified on his oath as follows:

19 MR. HEWSON: The record should reflect  
20 that this is the day and date set for the taking  
21 of the deposition of Dr. Steven Geiringer  
22 pursuant to Notice and further pursuant to the  
23 Federal Rules of Civil Procedure, and the  
24 deposition is being taken in lieu of the doctor's  
25 live appearance at the time of trial.

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1 EXAMINATION

2 BY MR. HEWSON:

3 Q. Dr. Geiringer, for the record would you identify  
4 yourself and give us your professional address?

5 A. Steve Geiringer, 36301 Warren Road in Westland.

6 Q. And what is your profession, sir?

7 A. I'm a medical doctor.

8 Q. And how long have you been a medical doctor?

9 A. 1979, so 33 years.

10 Q. Do you have a specialty?

11 A. I do, physical medicine and rehabilitation.

12 Q. Could you tell the jury what the specialty of  
13 physical medicine and rehabilitation entails?

14 A. That field is pretty much split into two, the  
15 physical medicine and then the rehab.

16 And the rehab side people might be more  
17 familiar with if someone's had a stroke or spinal  
18 cord injury, has MS, something like that. The  
19 rehab doctor will oversee all of the therapies  
20 and medications and treatments and try to get the  
21 person back hopefully as much as possible  
22 function-wise.

23 I practice on the physical medicine  
24 side which deals with musculoskeletal injuries,  
25 sprains or strains, ruptured disks, pinched

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1 nerves, making the diagnosis mostly by exam or  
2 testing and then overseeing treatment, therapy,  
3 medications, sending somebody for injections and  
4 hopefully get them back to Square 1, if not as  
5 much as possible.

6 DEPOSITION EXHIBIT 1  
7 curriculum vitae of deponent  
8 WAS MARKED BY THE REPORTER  
9 FOR IDENTIFICATION.

10 Q. Thank you. I've marked as Exhibit 1 your  
11 curriculum vitae and I'd ask you just to take a  
12 quick look at that, tell me if it's accurate and  
13 up to date as of today's date?

14 A. Pretty much. All the background information is  
15 the same. This is dated July, 2011 so there  
16 would only be a few additional presentations and  
17 things like that, but otherwise it's up to date.

18 Q. Thank you. So the record is clear, this is 33  
19 pages long, am I correct?

20 A. Yes.

21 Q. Rather than taking you through all 33 pages let  
22 me hit a few of the highlights. Are you  
23 presently affiliated with any hospitals?

24 A. No.

25 Q. And are you presently teaching anywhere?

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1 A. I am a clinical professor at Wayne State  
2 University.

3 Q. What does being a clinical professor mean?

4 A. In medicine it's different than being a professor  
5 in some other fields where's there's classroom  
6 teaching and things like that.

7 For me, for physicians it means when I  
8 go around the country to make presentations I'm  
9 there pretty much representing Wayne State as  
10 part of their faculty. So, an example, I just  
11 came back Saturday from our national -- yearly  
12 national meeting and had a couple presentations  
13 in that forum and it's through Wayne State that  
14 -- I've represented as through Wayne State.

15 Q. You are board certified in your specialty, is  
16 that correct?

17 A. Yes.

18 Q. And can you tell the jury how one becomes board  
19 certified?

20 A. Well, it's really a process starting with where  
21 you do your training, your specialty training,  
22 and my field of PM&R is one of the 24 major  
23 specialties, so all these fields you have to go  
24 to a program that itself is allowed to turn out  
25 board certified people or potentially.



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1 Every year along the way the person  
2 supervising you has to say yep, ready to move on  
3 to the next step. At the end of training that  
4 person has to say ready to sit for the exam.

5 In my field the initial certification  
6 is a two-year process, that year and the year  
7 after. And nowadays it's not just a one-time  
8 thing any more. You have to what's called  
9 maintain certification, so every year on an  
10 ongoing basis there are things, continuing  
11 education and all sorts of other things that has  
12 to be done to maintain certification.

13 Q. What does "board certification" mean?

14 A. Well, it's the only measure we have that somebody  
15 has attempted to take those steps and has  
16 succeeded in taking those steps that are meant to  
17 show that somebody is able to practice  
18 competently.

19 There's really nothing else in the  
20 field of medicine that one can turn to other than  
21 board certification.

22 Q. I know this is an obvious question, but you are  
23 licensed in the state of Michigan to practice?

24 A. Well, you have to be to be board certified, so  
25 yes.

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1 Q. Thank you. Now, in your curriculum on Page 3 you  
2 mention affiliations with University of Michigan  
3 Hospital, Rehab Institute of Michigan.

4 What do those affiliations mean?

5 A. Those were hospital or medical center  
6 affiliations when I was on the staff of those two  
7 organizations. After I finished my training in  
8 '82 I joined the faculty at Michigan and the  
9 staff of the medical center until '91 at which  
10 point I moved to Wayne State's faculty and the  
11 clinical staff of the Rehab Institute which is  
12 part of the Detroit Medical Center.

13 In '99 I went into solo private  
14 practice, so left the Rehab Institute DMC but  
15 still maintained the academic professor  
16 appointment at Wayne State.

17 Q. Now, you mentioned that you went into private  
18 practice in 1999. How much of your time is taken  
19 up with your private practice, not just the  
20 examinations that -- such as you did with  
21 Mr. Waskowski, how much of your time is taken up  
22 with your private stuff?

23 A. You mean treatment?

24 Q. Yes, sir.

25 A. Because it's all part of my private practice all

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1 rolled in together, but the treatment side is  
2 about 60 percent.

3 Q. And in Mr. Waskowski's case, how did he come to  
4 be seen by you, if you know?

5 A. He apparently was sent to me by what I call like  
6 a broker company that arranges for these  
7 evaluations to be done called MES.

8 Q. How long have you taken patients or gotten  
9 individuals for examination from MES, if you  
10 know?

11 A. Oh, I think since soon after I went into  
12 practice, so meaning '99.

13 Q. Can you tell me what if any way your examination  
14 would differ from one of the patients in your  
15 private practice and one of the patients you  
16 examine, for example, through an MES referral?

17 A. Again, I assume you mean a treatment patient as  
18 opposed to someone I'm seeing for evaluation  
19 only?

20 Q. Yes, sir.

21 A. There's no actual difference in terms of  
22 everything I do, the interview, asking them about  
23 their situation and the examination is identical.

24 One typical logistical difference is  
25 that folks I'm seeing for evaluation only often

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1 have a file of records that doesn't exist with  
2 somebody I'm seeing for treatment simply because  
3 when I treat somebody it's usually pretty quick,  
4 a work injury or car accident within the past  
5 short time, a few weeks or something.

6 So if there's any records, it might be  
7 an x-ray or something as opposed to if someone --  
8 for example, with Mr. Waskowski his car accident  
9 was a year and a half before I saw him and there  
10 were a couple of inches of records sent to me.

11 Q. Now, as you said in patients that are here to be  
12 treated by you, even if the prior medical history  
13 or medical records were brief you would normally  
14 get those as part of your treatment of that  
15 patient?

16 A. Well, it's always helpful for a physician to know  
17 what has already happened, if there's been any  
18 kind of imaging, x-rays or MRI scans, if they've  
19 been through treatment, therapy, whatever, yeah,  
20 it's always good to have those.

21 Do I always get them ahead of time, no.  
22 Then I request them for afterwards, but it allows  
23 you to focus your exam and your questions maybe a  
24 bit more on certain areas than others when you  
25 know what the main problem has been all along.

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1 Q. Now, you also have, I believe, a specialty in  
2 electrodiagnostic medicine, is that true?

3 A. Right, that's sort of a sub-board certification,  
4 right.

5 Q. And was the process the same to obtain that board  
6 certification as you described relative to your  
7 specialty in physical medicine?

8 A. It is what I would call a secondary board  
9 certification so it's not one of the primary  
10 fields of specialty. My field, pediatric  
11 surgery, that sort of thing, it is secondary and  
12 electrodiagnostic medicine has to do with a test  
13 called EMG and all the medicine that sort of  
14 surrounds that.

15 EMG is used in my field mostly to  
16 diagnose pinched nerves. Other fields might be  
17 muscle diseases or Lou Gehrig's disease, things  
18 like that in neurology.

19 But in my field it's mostly to diagnose  
20 pinched nerves like coming from the neck or back  
21 or like carpal tunnel, things like that.

22 Q. This may seem like a simplistic question, so  
23 please forgive me, but is the EMG a recognized  
24 diagnostic tool for physicians?

25 A. Yes. I mean there's an entire organization that

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1 has to do all with the field of medicine that  
2 surrounds EMG. There's a board certification  
3 examination about -- I think about 1,200 or 1,500  
4 people in the country are certified in EMG. It's  
5 a very well recognized study. It's been around  
6 since about the '50s and it got into more  
7 prevalence in the '60s and '70s and of course now  
8 it's very well recognized.

9 Q. And it wouldn't fall under the category of a test  
10 that has no medical foundation and is only there  
11 to line the pockets of the physicians that order  
12 EMGs, right?

13 A. Would EMG be considered that?

14 Q. Yeah.

15 A. No. I mean, EMG is a very well known and very  
16 well accepted and respected test when done  
17 correctly. Like every test, I suppose based on  
18 your question could someone do unnecessary EMGs,  
19 sure, like you can do unnecessary x-rays or  
20 anything else.

21 But no, it's a very well recognized and  
22 highly researched -- very highly researched  
23 study, exam.

24 Q. So I want you to assume for the sake of this next  
25 question that Dr. Glowacki said this is a lousy

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1 test, an EMG, that has no real value clinically.

2 Would you agree with that statement?

3 A. No, not at all.

4 Q. What is the first thing you do when you examine a  
5 patient?

6 A. In the room the first thing after introduction is  
7 to take a history which is basically an  
8 interview. On the typical symptom for people I  
9 see whether I'm treating them or not the most  
10 common symptom is pain, pain, numbness, tingling,  
11 weakness.

12 So you ask them what happened. In this  
13 case it was a car accident, but you ask them what  
14 they're feeling basically, do they have pain,  
15 where is it, what makes it better, what makes it  
16 worse, what treatments have you had, does it make  
17 it better or worse, all those sorts of things.

18 Have you had prior such problems or is  
19 this new since -- in this case it's the car  
20 accident.

21 Q. When was the first time that you saw Mr. -- I'm  
22 sorry, I believe it was the only time that you  
23 saw Mr. Waskowski?

24 A. It was the only time, that was July 7 of 2011,  
25 not quite the year and a half ago.

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1 Q. And what did he tell you relative to that  
2 historical inquiry?

3 A. He said he was operating his vehicle, was hit on  
4 the driver's side. He had symptoms in multiple  
5 areas. He was very clear that he was getting  
6 slowly worse as time went by. And then I ask  
7 people was there ever a time that you got a whole  
8 lot better but then something happened and you  
9 went south again.

10 No, he was very clear he had never  
11 improved even temporarily. He had low back pain  
12 that was in the middle and off to his left, not  
13 on the right. He had pain down the left thigh,  
14 through the left thigh toward the knee.

15 He then had neck pain also more on the  
16 left and all the way down the left arm to the  
17 wrist, and either wrist would sometimes swell,  
18 but more on the left.

19 So all of his sympt -- almost 100  
20 percent of his symptoms were on the left.

21 Q. Were you able to observe any swelling in his  
22 wrists during your examination?

23 A. When I examined him there was no swelling, no.

24 Q. What history did he give you, if any, relative to  
25 his treatment that he had received?



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1 A. He said he was seeing -- you mentioned  
2 Dr. Glowacki. He was seen by Dr. Glowacki. He  
3 had been in physical therapy three times a week.  
4 When I saw him it had been one and a half years  
5 since the accident and he told me he had been in  
6 therapy that entire time.

7 He mentioned modalities, what we mean  
8 like hot packs or things like that, ultrasound  
9 and exercise. Said he was doing exercises very  
10 regularly at home and that he was taking Vicodin  
11 for pain.

12 Q. In that connection is Vicodin the drug of choice  
13 I guess you would inartfully say for a person  
14 with what would be soft tissue injuries?

15 A. Well, Vicodin as it turns out is what is called  
16 an opiate medication, an opiate narcotic. And  
17 opiates have shown over the years and  
18 increasingly lately, more and more studies as  
19 time goes by, that they absolutely should not be  
20 used for chronic conditions because people do  
21 actually worse function-wise, function day by  
22 day, returning to work is worse with chronic  
23 opiates, and there's more and more evidence now  
24 that in fact they don't even make a noticeable  
25 difference in pain levels.

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1 People tend -- and in my office too --  
2 people tend to say well, you know, they helped  
3 short term, but you really want to keep opiates  
4 for more serious problems that are short term,  
5 certainly not for long term.

6 And general consensus or standards of  
7 practice would say that you don't use them for  
8 soft tissue strains.

9 Q. If medication is indicated on a person with soft  
10 tissue injuries, what medication do you  
11 recommend?

12 A. Typically it would be just an over-the-counter  
13 like Extra Strength Tylenol. Tylenol has been  
14 shown to be as effective as the  
15 antiinflammatories, but without the GI  
16 possibilities of GI distress.

17 An antiinflammatory like Motrin or  
18 Advil, something like that, Naprosyn, typically  
19 we're not talking about an actual inflammation  
20 situation, not usually.

21 For an acute ruptured disk there might  
22 be, so you might use antiinflammatories. For a  
23 soft tissue strain it's just the pain, so Tylenol  
24 is really quite effective. There's others like  
25 Ultram. By research studies if they're at all

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1 more effective than plain Tylenol or Extra  
2 Strength Tylenol, not by much.

3 Q. You mentioned that Mr. Waskowski gave you a  
4 history of physical therapy?

5 A. Yeah.

6 Q. You order physical therapy I assume for your  
7 patients?

8 A. Sure.

9 Q. When you're evaluating a patient for physical  
10 therapy what kind of concerns -- I'm sorry --  
11 what do you express to the physical therapist as  
12 to what you're looking for if you're specific  
13 when you're dealing with them?

14 A. Well, physical therapy is done for people who  
15 have an actual impairment or a condition that  
16 explains their symptoms and I would tell the  
17 therapist what the symptom is or what the  
18 condition is, what the diagnosis is.

19 And it depends on the therapist. There  
20 are a few therapists who I've sent people to for  
21 literally 20 years and I know that he or she  
22 knows exactly what I ask for, so I ask for the  
23 generalities, manual therapy, stretching,  
24 mobilization, that sort of thing.

25 If it's a therapist at a facility I

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1 don't know I give them much more detail than  
2 that.

3 Q. You mentioned diagnosis. What is "diagnosis",  
4 what is that?

5 A. Well, it's an actual condition so if somebody  
6 has, let's just say, back pain, that's a symptom.  
7 That doesn't tell you what's causing the back  
8 pain, but that will prompt the physician to look  
9 for what's causing the back pain, a muscle strain  
10 like muscle pull, ruptured disk, pinched nerve,  
11 whatever it might be.

12 That's the diagnosis, the actual  
13 condition that's causing your symptoms.

14 Q. Pain you said is a symptom, am I correct?

15 A. Yes.

16 Q. I've heard the word "subjective" versus  
17 "objective", objective signs or findings and  
18 subjective symptoms.

19 Could you tell the jury what the  
20 difference is between those things?

21 A. Anything that is a symptom that someone tells me  
22 they're feeling the pain, the numbness, the  
23 tingling, that is subjective. That is -- it goes  
24 through their brain and they have to interpret  
25 it. It's not something I can measure.

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1                   So someone says their back hurts a  
2                   little or a lot, it hurts 9 out of 10 or 1 out of  
3                   10, there's no machine that can measure pain.  
4                   There's really no machine that can measure  
5                   numbness or other things either. Those are all  
6                   subjective.

7                   Then it's up to the physician to look  
8                   for something that correlates with that,  
9                   something objective. So if I bend the person  
10                  forward and their back goes into a big twist or a  
11                  torque, that's objective. That's not within  
12                  their control.

13                  If I measure their calves because they  
14                  might have a pinched nerve and one calf is half  
15                  an inch smaller than the other and that goes  
16                  along with a reflex that's down on the same side,  
17                  the ankle, you know, tap with the reflex, those  
18                  things are not in the person's control.

19                  Those are measurable, those should be  
20                  reproducible from one person to the next if the  
21                  test has been done correctly. Those are  
22                  objective.

23       Q.       Was it your understanding from the history  
24                  Mr. Waskowski gave you that he had been in  
25                  physical therapy for the entire period of time

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1 from the accident up until the time he saw you?

2 A. He did, he said one and a half years which was  
3 pretty much exact amount of time -- I guess when  
4 I saw him -- yeah, it was a couple of weeks more  
5 than 1.5 years.

6 Q. What if -- are there any standards for the  
7 prescription of physical therapy that you deal  
8 with in your specialty, that is as to length of  
9 time and that sort of thing?

10 A. Sure. There are general sort of consensus  
11 opinions and there is something called the ODG,  
12 which stands for official disability guidelines.

13 For a strain, for a muscle pull, they  
14 would allow 10 visits, the ODG would. And then  
15 you have to go from there. If it's helping a lot  
16 -- you know, in my mind if I see somebody back in  
17 three weeks which is about eight or 10 visits and  
18 it's helping a lot, yeah, I'll give them another  
19 couple or three weeks maybe, a couple of weeks,  
20 see them back.

21 I've seen some physicians who I respect  
22 will say maybe two months even or something like  
23 that and the ODG, as I mentioned, would be 10  
24 visits. Those are some guidelines for soft  
25 tissue strains.

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1 Q. What do you as a specialist in physical medicine  
2 and rehabilitation do if the first 10 visits  
3 aren't working or if the person is getting worse?  
4 What do you do relative to physical therapy?

5 A. Well, there's two possibilities. One is that  
6 perhaps the physical therapist, the person  
7 they're seeing, there are certain techniques that  
8 not all therapists are trained in and maybe that  
9 person is the wrong therapist.

10 But typically therapists are -- you  
11 know, if they're doing what they're supposed to  
12 do and you've gone three weeks -- I allow three  
13 -- that's why I see people back after three weeks  
14 of therapy. After three weeks which is eight or  
15 nine visits, it's not going to suddenly change so  
16 you have to pretty much think, well, you know,  
17 maybe I have the wrong diagnosis or who knows  
18 what. So you got to change something.

19 In fact, there are physical therapy  
20 standards of practice within their own field.  
21 Their standards say that if therapy is  
22 ineffective you, the therapist, must discuss this  
23 with whoever ordered the therapy and alter  
24 something, do something different.

25 Q. And writing "pain" on a prescription form does

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1 not suggest any diagnosis if that's the only  
2 "diagnosis" on that piece of paper, am I correct  
3 in that?

4 A. Pain from the standpoint of can you find a  
5 diagnosis code in the book that -- you know, the  
6 CPT code, you can find a diagnosis code for pain,  
7 but medically it's not a diagnosis, it's a  
8 symptom.

9 The diagnosis would be, for example,  
10 lumbar strain in a muscle pull or herniated disk,  
11 ruptured disk, so pain is not medically a  
12 diagnosis.

13 Q. After you conclude the history portion of your  
14 examination did you -- what do you do next or  
15 what did you do in regard to Mr. Waskowski?

16 A. What I do in my office is leave the room, have  
17 them change into a gown while I dictate the first  
18 portion that we just talked about, the history.

19 Then I go back into the room and  
20 examine the person, do the physical examination.

21 Q. And could you tell the jury what your physical  
22 examination of Mr. Waskowski included?

23 A. Now, do you want to have me give you the general  
24 exam and then --

25 Q. If you wouldn't mind, if you can tell us the



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1 general exam and then I'll ask about specific  
2 findings?

3 A. Okay, all right. The general exam is split into  
4 two parts, what I call the musculoskeletal and  
5 then the neurologic. The musculoskeletal, for  
6 example, would look mostly for muscle pulls or  
7 muscle strains, so things like in the low back --  
8 and these all translate kind of to the neck too.

9 But in the low back having the person  
10 move around in six different directions, does it  
11 hurt, where does it hurt, which motions make you  
12 feel better, which make you feel -- the back feel  
13 better or worse, that sort of thing. Is the back  
14 motion even and smooth or is there a torque or a  
15 twist on the back like I kind of mentioned  
16 before, which means the muscles are more tight on  
17 the one side than the other.

18 Palpation which is basically pushing  
19 over the muscles where the muscles attach, where  
20 nerve runs through, that sort of thing, does it  
21 hurt. And if it does hurt, if the muscles are  
22 tight for even a few weeks, certainly a month or  
23 more, they feel abnormal.

24 People describe like a twine, a ropy  
25 kind of feeling, orange peel, orange rind or

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1 something, but they feel abnormal to the  
2 experienced fingers; look for that.

3 The neurologic is basically looking for  
4 -- the other half of the exam -- basically  
5 looking for a pinched nerve, so running from the  
6 back down the leg or from the neck down the arm.  
7 Tapping on the reflexes with the hammer, testing  
8 strength, push against me or squeeze my fingers,  
9 is there a difference from side to side.

10 Atrophy meaning if there's been a  
11 pinched nerve -- nerve damage to a muscle that  
12 calf might be smaller, the thigh might be smaller  
13 depending on which nerve. Sensation, can you  
14 feel the touch or the pin, whatever you use, the  
15 same on one side or the other and if you can't,  
16 if it's different on one side, is it pretty close  
17 to a typical what we know as a nerve  
18 distribution, a nerve pattern, or not.

19 Q. Thank you. You went through all of that physical  
20 examination with Mr. Waskowski, am I correct?

21 A. Yes.

22 Q. Can you tell the jury what if any findings you  
23 made that you considered significant in regard to  
24 Mr. Waskowski after that -- or during that  
25 physical exam?

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1 A. Okay. The first thing I mention in my report --  
2 and I'm using my report to refresh my memory  
3 since this was a year and a half ago -- was that  
4 there was great deal of what I call pain  
5 behavior.

6 Q. What is that?

7 A. Pain behavior is something that we all exhibit at  
8 some point. You know, if you're not feeling well  
9 and you tell your wife to get you a glass of  
10 orange juice, you could do it yourself, but it's  
11 easier for someone else to do it. That's pain  
12 behavior technically, but that doesn't interfere  
13 with your life or dictate how you really act all  
14 the time.

15 Pain behavior during an examination is  
16 -- and again some is perfectly normal -- is what  
17 I mentioned here, a great deal of pain behavior,  
18 grunting, panting, pulling away, things like  
19 that, a lot of verbalization, things like that.

20 The other thing I mention was as soon  
21 as I told him that go ahead and change into a  
22 gown, I was leaving the room as I mentioned, his  
23 wife jumped up out of her chair and came to his  
24 assistance. He's a big muscular guy, but came to  
25 his assistance to get changed.

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1                   And she did the same several times  
2                   during the physical examination when he was  
3                   trying to get onto the table, turning over, she  
4                   jumped to his assistance several times.

5                   So that's sort of a correlate to pain  
6                   behavior.

7       Q.       Why is that significant?

8       A.       Well, I talk later about the disability mentality  
9                   and when you -- I mentioned before have somebody  
10                  else go get you the glass of orange juice. If  
11                  that turns into day by day, month by month and  
12                  year by year, and this was a year and a half  
13                  later, that obviously has a huge effect on your  
14                  level of functioning secondarily and just how you  
15                  view yourself.

16                So the disability mentality is Mr. --  
17                  in this case Mr. Waskowski thinking that he's  
18                  disabled and his wife sort of going along with  
19                  that and helping him, you know, helping him move,  
20                  turn over for example.

21       Q.       Were there any physical findings after that  
22                  observation that were significant to you?

23       A.       Well, the first thing was having him move in six  
24                  different directions of the low back.

25       Q.       Could he do that?

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1 A. Huh?

2 Q. Could he do that?

3 A. Well, he -- what I said he had about 5 percent of  
4 flexion, 5 percent of what I would expect to be  
5 normal for someone his age. He had about 5  
6 percent of that.

7 He had zero extension. He could not  
8 tilt backward at all in any of the three  
9 directions. All of those he said caused severe  
10 pain or when he did move, he anticipated severe  
11 pain with any of those motions.

12 Significance is that there is nothing  
13 short of cancer eating away at your spine that  
14 allows essentially zero motion in any direction.  
15 In fact, actual conditions like a ruptured disk  
16 or even strains, some motions feel better.  
17 That's just -- that's the pattern I look for.

18 If this is a ruptured disk, certain  
19 patterns that sort of turn that light bulb on in  
20 my head, but this pattern, there's really nothing  
21 that causes that.

22 Q. Can you tell me what your understanding is of why  
23 some of those motions would actually make you  
24 feel better if you have a real ruptured disk?

25 Why would that occur?

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1 A. Well, to take the example of a ruptured disk,  
2 there is typically swelling around the disk or  
3 even if there's not, if you're past that acute  
4 stage there's a physical thing there, there's a  
5 gumba there, there's disk material there.

6 If you tilt backwards -- and it's off  
7 to the back and the side if you look at the  
8 spine. So if you tilt backwards and to that  
9 direction you're going to literally crunch that  
10 area or the swelling around it which itself can  
11 then crunch the disk and cause pain.

12 But just the opposite is true. If you  
13 bend forward on the opposite side or even forward  
14 to the same side, but especially opposite that at  
15 a diagonal opposite, it takes the pressure off  
16 the area and it feels better, and the other  
17 motions are kind of in-between. So that's just  
18 an example of that.

19 The next thing I look for is I  
20 mentioned if there's a twist or a torque on the  
21 spine. Is the motion symmetric or is it  
22 asymmetric and he had very little flexion, very  
23 little bending forward, but whatever there was  
24 was normal. But you can also test that when  
25 they're lying down by looking at their different

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1           anatomic areas, ankles and the hips, and there  
2           was no asymmetry, in other words, he was lined up  
3           okay.

4       Q.   Let me ask you this too and I don't mean to  
5           interrupt you, but you mentioned that he was a  
6           big muscular guy?

7       A.   Well, what I said was he was well muscled.

8       Q.   And is that significant in your observation of  
9           the patient who claims to have had this kind of  
10          problem for 18 months?

11      A.   I would say overall no. I mean, just because  
12          he's more heavily muscled does not mean he could  
13          not have a ruptured disk that is just as painful  
14          as somebody thinner or -- not necessarily.

15      Q.   Very good. After the observation relative to his  
16          back, what if anything next did you find?

17      A.   Next thing I talked about was what's called  
18          straight leg raise, so that's done in two ways.

19                       First the person is lying flat out face  
20          up and without their help I take one leg at a  
21          time and slowly move it up, ask him though to  
22          tell me what he's feeling. And on the right side  
23          he had low back pain at about 5 or 10 degrees,  
24          meaning the leg was barely off the table a couple  
25          of inches.

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1                   On the left side there was severe low  
2                   back pain at -- what I said zero to 5 degrees,  
3                   so, you know, maybe an inch off the table. Now,  
4                   that is done later in a different way. The  
5                   person sitting over the side of the table and I'm  
6                   testing their strength in their foot and  
7                   something like that, but I'm also lifting their  
8                   leg up to basically cause also a straight leg  
9                   raise.

10                  And in that part of the test he had no  
11                  pain whatsoever and I got him to 80 degrees.  
12                  Now, that's a big difference. Those two are not  
13                  exactly equivalent lying out flat and then  
14                  sitting, and if there were a 20 degree  
15                  difference, if somebody said oh, yeah, that hurts  
16                  at 40 degrees and I could do it to 60 sitting,  
17                  that's fine.

18                  Zero to 5 degrees versus 80 degrees is  
19                  a huge difference, meaning that if there were an  
20                  actual structural problem -- and what you're  
21                  looking for is tension on the nerve causing the  
22                  first, it should -- it would have to be there at  
23                  the second.

24                  So what this tells me it's a big  
25                  discrepancy and there really is actually no



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1 structural problem causing that first severe pain  
2 at zero to 5 degrees.

3 Q. What does straight leg raising supine or laying  
4 down, what does that test for?

5 A. It's meant to look primarily for tension on a  
6 nerve root so you have a pinched nerve. It will  
7 be irritated and if you stretch it by doing the  
8 straight leg raise, it causes more pain.

9 It also might bring out muscle  
10 tightness in a back or the hamstrings or anyplace  
11 else, but the same holds true. The two done in  
12 two different ways should be about the same.

13 Q. Is there any known musculoskeletal condition that  
14 would explain the difference between his  
15 presentation for straight leg raising while he  
16 was laying down and sitting on the side of the  
17 table, basically at a 90 degree angle?

18 A. There's no condition that would explain that, no.

19 Q. What, if anything else, did you notice relative  
20 to his presentation on the physical examination?

21 A. The next part of the musculoskeletal exam was  
22 palpation, pushing over not just the back muscles  
23 but where they attach and other areas.

24 He had tenderness pretty much  
25 everywhere on the left side more than the right,

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1 but all through the muscles of his back for  
2 example. And I mentioned earlier that muscles  
3 will have a different feel to them if they've  
4 been tight for a few weeks, certainly a month or  
5 more. This had been a year and a half. Even  
6 though he was saying there was severe pain and  
7 there was also tenderness when I pushed over him,  
8 the muscles had completely normal feel to them,  
9 so it's another discrepancy.

10 Q. What did you examine next?

11 A. Then came the neurologic and all the parts I  
12 mentioned before, the reflexes, the strength,  
13 atrophy meaning measuring if there was any loss  
14 of the muscle mass, sensation, all that were  
15 completely normal in the legs.

16 Q. Did you find any evidence of diminished sensation  
17 in the L4-L5 nerve root distribution?

18 A. There was none.

19 Q. Could you tell the jury and me when we talk about  
20 nerve root distribution what that means?

21 A. Well, there's the major nerves that run down the  
22 arm or run down the leg. For the leg, for the  
23 low back, lumbar area the ones that supply the  
24 leg muscles mostly are L4 and L5, lumbar 4 and 5  
25 and S1, sacral 1.

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1                   And so each of those has a -- you know,  
2                   from the anatomy textbook we're all different a  
3                   little bit, but they pretty -- we're pretty  
4                   consistent and each of those has a pattern of  
5                   muscles that it supplies and a pattern of skin  
6                   that supplies the sensation to.

7                   And so I mentioned before touching or  
8                   people use a pin, if they're numb or feel less in  
9                   a certain distribution does that match or pretty  
10                  closely match one of these major nerves.

11       Q.       And there were no findings relative to L4-L5?

12       A.       They were not, either sensation-wise or  
13                  strength-wise or reflex-wise.

14       Q.       Can you tell me what extensor hallucis longus is,  
15                  please?

16       A.       EHL, extensor hallucis longus, is the muscle that  
17                  pulls up the big toe.

18       Q.       Did you find any neurological compromise to that  
19                  in your examination?

20       A.       No, it was fully strong.

21       Q.       What if any finding did you make relative to  
22                  Mr. Waskowski's ability to raise and lower his  
23                  foot? Did you check that?

24       A.       Yeah, it's called ankle dorsiflexion,  
25                  plantarflexion, all that was normal

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1 strength-wise. He was very strong.

2 Q. Now, did that conclude your examination of his  
3 legs or was there more that you had done?

4 A. Other than watching him walk, and I said that his  
5 -- how he walked was mechanically normal meaning  
6 all the aspects of how you actually walk, putting  
7 it all together, but he was holding his -- or he  
8 was on his wife's arm for support, but his  
9 walking was otherwise normal.

10 And then I went on to the neck and  
11 arms.

12 Q. Before we move on to those, if you have -- what  
13 if any balance difficulties did Mr. Waskowski  
14 describe to you?

15 A. I don't believe he told me about balance, he  
16 didn't mention any balance issues at all.

17 Q. And he did not appear at your office with a cane  
18 or a walker or wheelchair or anything like that?

19 A. No, and his balance -- you know, when I have  
20 people move around, he didn't move much, but when  
21 I have them move around, if they have balance  
22 problems they usually grab a table or something  
23 and that didn't happen.

24 Q. When you moved on to the neck and arms, you  
25 conducted a physical examination of those areas

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1 as well?

2 A. All the same components we mentioned before.

3 Q. Could you tell the jury what your findings were  
4 relative to the neck and arms?

5 A. Well, in the neck -- and I put people through,  
6 again, six different motions and there was in  
7 this case zero. He did not move his neck in any  
8 of the six directions at all.

9 And, again, I mention that maybe short  
10 of, again, cancer eating away at your spine or  
11 something like that, there's no musculoskeletal  
12 condition, there's no strain or ruptured disk or  
13 pinched nerve that causes that.

14 All of those he said he would have  
15 severe pain, but he didn't move at all. He was  
16 just anticipating severe pain. There's a  
17 maneuver called a Spurling where you position the  
18 head backwards and off to the side and put a  
19 little pressure down, see if it irritates a nerve  
20 root. Couldn't do that because he had to move  
21 the neck and he didn't move the neck at all.

22 Despite his severe pain, when I  
23 palpated, when I pushed firmly over his neck and  
24 shoulder muscles there was no tenderness  
25 whatsoever with pretty deep palpation, and like

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1 the low back, those muscles had normal tone,  
2 normal texture, meaning they hadn't been tight at  
3 all recently.

4 Otherwise, I would have felt something  
5 there.

6 Q. What if any findings did you make in the arms?

7 A. I then did the neurologic, all the same things we  
8 talked about. Everything was normal strength and  
9 all that, reflexes except that he -- in the  
10 entire left arm he said it felt more numb to him  
11 than the right. The right felt normal, the whole  
12 right arm and the left arm, the entire left arm  
13 didn't feel the same.

14 I mentioned earlier that we look for  
15 numbness or decreased sensation in a certain  
16 nerve pattern, and that would mean something if  
17 it went along with other things. The entire arm  
18 being numb again is not from any -- there's no  
19 known condition not musculoskeletal -- I mean a  
20 stroke, something like that, but in what I'm  
21 looking for in Mr. Waskowski there's no known  
22 condition that would possibly cause that.

23 Q. While we're talking about the arm, could you tell  
24 the jury where the carpal tunnel is in the body?

25 A. The carpal tunnel is at the front of the wrist

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1 and it goes from like the farther wrist line to  
2 about an inch or so where the palm sort of dives  
3 down. It's an area, a tunnel created by bones on  
4 the bottom and a ligament over the top.

5 Q. You noted in your report that there was no focal  
6 atrophy in the arms, is that correct?

7 A. Yes.

8 Q. Why is that significant?

9 A. I mentioned earlier that a pinched nerve if it's  
10 there long enough and bad enough can cause the  
11 muscle fibers to lose their nerve supply and they  
12 can shrink, that's atrophy.

13 Q. Now, at the time of your initial --

14 A. Can I add one more thing?

15 Q. I'm sorry, please.

16 A. There was just one more thing I did in the arm  
17 and that was on the left to test his rotator  
18 cuff.

19 Q. And could you tell the jury what the rotator cuff  
20 is?

21 A. Sure. It's a group of four muscles that comes  
22 from the shoulder blade up to the upper arm bone,  
23 the humerus, and just like it sounds it rotates  
24 the upper arm, very important for quarterbacks  
25 and pitchers, and we all do some motions that

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1 involve the rotator cuff.

2 There are certain maneuvers that are  
3 specific for the rotator cuff and cause pain in a  
4 certain distribution and when I tested him he  
5 didn't have that pattern of pain.

6 Q. Did he or the person that was with him ever  
7 suggest to you or tell you that he had a history  
8 of post-traumatic stress disorder?

9 A. No. His wife was there, but also an interpreter  
10 was there, but I mentioned earlier in this report  
11 that I was able to get a full history, do a full  
12 exam even with an interpreter present, but no, no  
13 mention of PTSD.

14 Q. Now, your initial report you deferred your  
15 discussion. Why did you do that?

16 A. I had been sent a file of records a couple of  
17 inches I had mentioned before, but apparently it  
18 must have gotten to my office that day, day  
19 before, hadn't had a chance to look at them yet.

20 So I was going to defer final opinions  
21 until I did have a chance to look at those  
22 records, which I guess I did four days later.

23 Q. Now, what part does reviewing medical records  
24 play in your examination and evaluation of the  
25 patient?



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1 A. I talked about earlier that it might help focus  
2 what you examine, but more importantly it just  
3 gives me insight into what others have found,  
4 what have they documented on examination, what  
5 the symptoms were, what the physical examination  
6 findings were.

7 I'm often asked in these kinds of  
8 evaluations, "Was the treatment medically  
9 necessary?" so that gives me some insight into  
10 that as well, all those kind of questions.

11 Q. Now, when you receive records such as were  
12 presented to you in this case, you don't  
13 investigate whether or not the findings are  
14 accurate or whether they're authored by the  
15 person or authentic or any of that I assume, is  
16 that correct?

17 A. That's correct in terms of being authentic. When  
18 you say "accurate", I'm not sure what you mean.  
19 I mean, I can look at the content of the notes  
20 medically, but in terms of whether Dr. X, Y or Z  
21 actually authored the notes, I don't get into  
22 that.

23 Q. Did you have a chance to review these records  
24 that were presented to you?

25 A. Yes, I did.

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1 Q. And can you tell the jury what, if anything, you  
2 found significant in your record review?

3 A. Well, the early notes mentioned spine and  
4 left-sided pain. He did not lose consciousness.  
5 Most medical notes were from the person you  
6 mentioned before, Dr. Glowacki, and he first saw  
7 Mr. Waskowski three weeks later. Neck and low  
8 back pain, there was no mention of the shoulder,  
9 the arm or the leg anywhere.

10 However, Mr. Waskowski told him he  
11 couldn't dress himself, he couldn't take a shower  
12 himself, he couldn't do virtually anything for  
13 himself. There was tenderness in the spine and  
14 reduced motion. The left ankle reflex was said  
15 to be gone, said to be zero.

16 Dr. Glowacki mentioned rib and  
17 breastbone, sternum, fractures because of  
18 tenderness there and later in the records the  
19 imaging for that, for both those areas, was  
20 completely normal. There were no fractures  
21 there.

22 He then recommended MRI scans, physical  
23 therapy, what we call household assistance and  
24 attendant care, someone to basically take care of  
25 the house and Mr. Waskowski's personal care,

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1 personal needs.

2 Q. I'm sorry if I --

3 A. All right.

4 Q. The issue of the bone scan and the x-rays, you've  
5 had a chance to look at those reports, am I  
6 correct?

7 A. The reports. I don't think I saw those actual  
8 images. I know I didn't see the bone scan. I  
9 don't think I saw the rib x-rays either.

10 Q. You saw the reports of those studies?

11 A. Yes.

12 Q. And will x-rays show fractures of the sternum and  
13 the ribs?

14 A. Yes.

15 Q. Is it true that 90 percent of the time x-rays  
16 will miss fractures of the ribs or the sternum?

17 A. 90 percent you say will miss them, will not show  
18 them?

19 Q. Yes.

20 A. No. Now, I will say that there are occasional  
21 rib fractures non-displaced so they're not out of  
22 place early on where the calcium -- what we call  
23 the callus, hasn't formed yet, but within a  
24 couple of days that will show up.

25 Q. How about with the bone scan, if there's a bone

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1 scan that's done as you saw in this particular  
2 case, would that pick up fractured sternum and  
3 fractured ribs?

4 A. Yeah, right away. I was just looking for --  
5 yeah, immediately for the bone scan. I was just  
6 looking for the date of the rib x-rays showing no  
7 fractures. That was on 1-4-10 meaning it was 9  
8 plus 4, 13 days, about two weeks later, so  
9 there's no question that calcium would have  
10 clearly formed by then.

11 So while an x-ray immediately might not  
12 show a rib fracture, by 13 days there's no  
13 question it would if it were there.

14 Q. If you had suspected fractures of the ribs or the  
15 sternum and received those x-ray and bone scan  
16 reports would you have continued a diagnosis of  
17 fracture of the ribs and sternum?

18 A. Well, in my report, in the second report I made  
19 that point that Dr. Glowacki did continue listing  
20 that as -- both of those as diagnoses obviously  
21 incorrectly.

22 Q. What was the date on your second report?

23 A. July 11, 2011.

24 Q. Thank you. What if anything else did you find  
25 significant from your review of the records?

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1 A. Well, I mention that he, Dr. Glowacki's, next  
2 three notes January, February, March one each  
3 2010 were completely illegible.

4 That reason alone means they didn't  
5 rise to what we consider minimal standards of  
6 medical practice. You have to create legible and  
7 reproducible reports.

8 Q. Why is that?

9 A. Well, for the sake of medical documentation. If  
10 somebody else -- if Dr. Glowacki somehow weren't  
11 available and someone else were trying to treat  
12 Mr. Waskowski for something that was there you  
13 have to create legible notes. It's basic for the  
14 sake of the patient's medical care.

15 It seems pretty obvious. And I'm  
16 pretty good at deciphering physicians  
17 chicken-scrawls. I couldn't read a thing in any  
18 of those three notes.

19 Q. Very good. What if anything else did you find?

20 A. Well, the next note was in April of 2010. There  
21 was no examination. Dr. Glowacki did not think  
22 that PT would help, which I found interesting. I  
23 didn't comment it here, but that was after  
24 probably three months of therapy, but the therapy  
25 went on for another year plus after that.

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1 He did think though that Mr. Waskowski  
2 might need an operation for his neck or his back.  
3 He later reports he listed MRI results. A note  
4 in June of 2010 said he was going to try to push  
5 him back to work. The next month though, July of  
6 2010, there was zero motion in the neck or the  
7 low back, essentially what I found one year  
8 later.

9 His diagnoses continued to include  
10 fractured sternum, fractured ribs incorrectly.  
11 On December 10 of 2010 we were now six months --  
12 oh, no, a year, I'm sorry, we were a year after  
13 the accident. There was a new finding of reduced  
14 sensation down the left arm in a certain nerve  
15 distribution a year later.

16 There were 12 more visits after that  
17 date, nine were completely unreadable. I could  
18 not decipher any physical examination.

19 Dr. Glowacki's note of -- in March of  
20 2011 showed no change in his pain. He called the  
21 pain bitter. He mentioned -- that's a word he  
22 used. And then toward the end of his notes which  
23 was ending in June of 2011 because I was seeing  
24 him the next month he put in his note that  
25 Mr. Waskowski will have pain the rest of his

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1 life, even if he has an operation from these  
2 issues.

3 Q. What if any evidence did you find as a result of  
4 your review of those records and your examination  
5 to indicate that that statement was true, that is  
6 that there would be pain there for the rest of  
7 his life?

8 A. We talked earlier about pain being a subjective  
9 symptom. There's no way to measure it, so if  
10 someone just tells me, "I have pain" and they  
11 tell me 20 years from now, "I still have pain and  
12 I've had pain since I saw you the first time 20  
13 years ago," there's no way to say, "No, you don't  
14 have pain" or, "You didn't have pain" or, "Yeah,  
15 you did have pain."

16 All a physician can do, mostly by exam  
17 but also with some other tests, is to find a  
18 cause of that pain. Is there anything that  
19 explains this pain? Is there a reason for that  
20 pain to be there or is it what we call  
21 non-organic, no explainable reason for the pain?

22 So there's no organic reason in the big  
23 picture after having all the records and having  
24 examined Mr. Waskowski, there was no hint of an  
25 organic reason, an actual condition, what we call

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1           impairment, to explain any pain at the moment or  
2           certainly the rest of his life which that  
3           statement by Dr. Glowacki, it doesn't make any  
4           medical sense either.

5                       There are few conditions in my field,  
6           again cancer and whatnot, but very few conditions  
7           -- well, there's none that I can think of, zero,  
8           that cause pain the rest of your life.

9                       That just isn't the way the body works.

10    Q.    What other records did you review?

11    A.    There was an orthopedic person who recommended  
12           spine injections, but later also said maybe he  
13           needs a neck or a back fusion.

14                       There was one note from Dr. Zamorano,  
15           also not board certified, who recommended EMGs or  
16           I think she did EMG in all four limbs.

17                       I talked about how much she billed for  
18           that and for other -- for like a lumbar corset  
19           and a cervical collar. There was an orthopedic  
20           evaluation in July of 2010 that concluded there  
21           was amplification of symptoms, meaning  
22           Mr. Waskowski was expressing a lot more symptoms  
23           than could be explained. And then there were a  
24           bunch of imaging studies, x-rays and MRI scans.  
25           The bone scan we talked about.



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1 Q. Those imaging studies that you reviewed, did you  
2 ever have a chance to review the report from  
3 Dr. Quinn? I don't know if you did or not, but  
4 --

5 A. No, I did not.

6 Q. As a result of your review of all these records  
7 and your physical examination of Mr. Waskowski,  
8 were you able to come to a diagnosis -- or let me  
9 ask you that question first -- come to a  
10 diagnosis relative to his condition?

11 A. Well, there was no musculoskeletal or neurologic  
12 diagnosis because there was -- not only was there  
13 no impairment, no actual condition found, but the  
14 only findings if you will were inconsistent or  
15 non-organic. Things like the straight leg raise  
16 we talked about before 5 degrees versus 80  
17 degrees, numbness in the entire left arm is not  
18 organic, that doesn't happen. Stroke, yeah, but  
19 not in this setting.

20 The huge amount of pain behavior,  
21 palpating the muscles that were very tender with  
22 minimal pressure even though they felt perfectly  
23 normal, so there was no musculoskeletal or  
24 neurologic diagnosis.

25 Q. What if any finding did you make regarding the

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1 necessity of a repeat series of MRIs at Oakland  
2 MRI?

3 Did you make a conclusion relative to  
4 that?

5 A. I had concluded that there was reasonable -- a  
6 medical reason I should say to do one set of MRI  
7 scans, no reason to do any more than that, not as  
8 relates to the accident we're talking about.

9 Things don't change that quickly in the  
10 spine, they change over years as a natural  
11 process of aging and there was also nothing on  
12 examination when I examined Mr. Waskowski and  
13 apparently the other person too, but my exam  
14 hinting of anything related to the disk.

15 I mentioned earlier the patterns of the  
16 way the back moves and the disk. If there's a  
17 disk problem might feel better in certain -- none  
18 of that was present at all, not even a hint of  
19 that, so there would have been -- in fact one  
20 could argue whether the first set of MRI scans  
21 was even necessary because of that.

22 There are radiology guidelines that say  
23 there should be worrisome symptoms, progressive  
24 neurologic deficit, not just back pain, and those  
25 weren't present.

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1                   So one could argue about even the first  
2                   set, but I would say okay, it's standard of  
3                   practice to get the first set of MRI scans.  
4                   There's no need for anything beyond that.

5       Q.       This 18 months of physical therapy, did you have  
6                   an opinion as to whether or not that was  
7                   reasonable in these circumstances?

8       A.       We touched on that before. If one says there  
9                   might have been strains to begin with, muscle  
10                  pulls, muscle strains in the neck and low back.  
11               Those weren't documented by Dr. Glowacki's input,  
12               but if they were there, a month of PT is what's  
13               considered justified.

14               We talked before, the ODG says 10  
15               visits, that's about three weeks if it's three  
16               times a week. I would say a month.

17               If the person is doing a whole lot  
18               better when I see him back I might give him  
19               another couple, three weeks, some people say two  
20               months. But at that point, you know, the way I  
21               word it is it makes not only no medical sense,  
22               but it makes no just general common sense to keep  
23               up with a year and a half of treatment that  
24               Mr. Waskowski basically says is worthless. He  
25               was no better at any time, not even temporarily.

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1                   In fact, he was slowly worsening over  
2                   time. So to provide that such therapy, there's  
3                   no possible justification for it, no explanation  
4                   for it.

5    Q.   Is it normal for a person of -- I believe  
6           Mr. Waskowski was 46 years old when he came to  
7           see you or close to 46?

8    A.   He was 48 when I saw him, but it had been a year  
9           and a half, so maybe he was 46 at the time of the  
10          accident.

11   Q.   Do you expect degenerative changes in the spine  
12          of a person of that age?

13   A.   Yeah, those are there if you look for them by --  
14          in many people by 35, a lot of people by 40, all  
15          of us by 45 or 50. Certainly 100 of us to some  
16          extent.

17                   Choosing your grandparents or  
18                   great-grandparents will tell you if there's a  
19                   little bit or a lot. So make sure you choose  
20                   wisely, but it's going to be there.

21   Q.   So if the suggestion was made by Dr. Glowacki  
22          that there would be no reason to believe that  
23          there was degenerative changes in the spine of  
24          Mr. Waskowski, would you agree or disagree with  
25          that proposition?

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1 A. You mean because of his age at 46?

2 Q. Because of his age at 46?

3 A. Well, 100 percent of people have changes in their  
4 spine, so that's fully incorrect.

5 Q. I'm trying to phrase this question eloquently,  
6 but I don't know how to do it. If you don't find  
7 that there's any organic reason to explain pain  
8 and there's no impairment, is there any way to  
9 say that he was injured in this accident from  
10 your examination?

11 A. Well, remember we have to separate symptoms from  
12 an actual condition.

13 Q. Yes, sir.

14 A. So when someone tells me they hurt, they hurt.  
15 My job, whether I'm treating them or whether I'm  
16 seeing them for evaluation only, is to look for  
17 the injury, look for the actual condition that is  
18 causing the ongoing pain.

19 A lot of people have -- whether it's a  
20 small or a large accident and to me the amount of  
21 damage doesn't make much difference, I've seen it  
22 all different ways. You have an impact to the  
23 spine, you can get -- the muscles are jarred,  
24 what we call the soft tissues, ligaments and  
25 connective tissues, and people hurt for a few

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1 days to a few weeks or something like that.

2 Beyond that, you get contusions,  
3 bruises basically of the muscles of the bone and  
4 that can hurt for a few weeks to a month or so  
5 and then you get into other things like ruptured  
6 disks or pinched nerves, or full-blown strains  
7 and those can hurt anywhere from a few weeks to a  
8 few months, several months if it's a ruptured  
9 disk, and that's where you need actual treatment.

10 There is nothing in this file from  
11 Dr. Glowacki or the imaging studies or from when  
12 I examined him a year and a half later to show  
13 that there was any actual condition that occurred  
14 on December 23 of '09.

15 Did he get bounced around? He  
16 certainly could have gotten bounced around, so  
17 the initial aches and pains could certainly --  
18 were probably undoubtedly there, but in terms of  
19 ongoing for a year and a half, you know -- the  
20 other point too is that a year and a half of  
21 therapy, we talked about it doesn't make sense to  
22 keep going with what is essentially worthless  
23 therapy, but actual medical conditions get  
24 better, not only with time, but also with  
25 treatment.

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1                   So there's virtually nothing anybody  
2                   can think of that lasts for a year and a half  
3                   without getting better. Now, add in if there was  
4                   something real and you're getting therapy aimed  
5                   at it, you know, he was getting worse over time.

6                   There's really no known condition that  
7                   fits that pattern.

8       Q.       Could you tell me if you were going to determine  
9                   in a particular patient that they needed  
10                  attendant care, what types of things would you  
11                  evaluate or look for if you were going to make  
12                  that decision for one of your patients?

13      A.       The most common reason for attendant care in my  
14                  field but that I don't deal with is head injury,  
15                  an actual brain concussion, long-lasting  
16                  concussion, brain injury, TBI.

17                  From the musculoskeletal standpoint  
18                  there is virtually nothing, virtually nothing  
19                  that requires attendant care. Now, that's not  
20                  household assistance or replacement services.  
21                  You're asking only about attendant care.

22      Q.       Yes, sir.

23      A.       So that's personal, you know, bathing and  
24                  dressing and brushing one's teeth and washing  
25                  one's hair and showering, that sort of thing.

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1                   There is almost nothing you can think  
2                   of. Now, if one has just had an operation, you  
3                   just had a back fusion or neck fusion or a  
4                   shoulder operated on for the rotator cuff, sure,  
5                   in the postoperative area a few weeks or  
6                   something before you get back on your feet.

7                   But from ongoing conditions, I do  
8                   request attendant care in other settings, but for  
9                   a simple straightforward musculoskeletal  
10                  condition, even if there were a ruptured disk,  
11                  even if there were pinched nerves, certainly  
12                  strains, those do not require attendant care  
13                  medically.

14    Q.    There are devices also to assist persons who are  
15           physically disabled, am I correct?

16    A.    You mean like reachers and things?

17    Q.    Reachers and long-handled sponges and that sort  
18           of thing.

19    A.    Right.

20    Q.    Did Mr. Waskowski ever mention to you or the  
21           person who was there with him or his interpreter  
22           tell you that anyone had ever prescribed any type  
23           of assistive devices for him when you saw  
24           Mr. Waskowski?

25    A.    He didn't offer that, but to be fair I didn't ask



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1 him.

2 Q. Would you have prescribed any for him?

3 A. No, there is no medical need for that.

4 Q. Last thing I want to ask you is, what is  
5 malingering?

6 A. Malingering has a specific diagnosis -- or a  
7 specific definition. In fact, that's the only  
8 possible diagnosis I raised here. That is a  
9 conscious effort on the part of somebody to  
10 appear disabled or when they act disabled when  
11 there is no medical reason for that disability.

12 Q. Was that part of your diagnosis for  
13 Mr. Waskowski?

14 A. In the end that was really the only diagnosis.

15 DEPOSITION EXHIBIT 2  
16 reports dated 7-7-11 and 7-11-11  
17 WAS MARKED BY THE REPORTER  
18 FOR IDENTIFICATION.

19 Q. Sir, I'm going to show you what I've marked as  
20 Exhibit 2. I believe I've stapled together both  
21 of your reports. If you could take a look and  
22 make sure those are accurate copies of your  
23 reports?

24 A. Yes, they are.

25 MR. HEWSON: I will move the admission

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1 of my two exhibits and I have nothing further of  
2 the doctor at this time. Thank you, sir.

3 THE WITNESS: Okay.

4 EXAMINATION

5 BY MR. TEMROWSKI:

6 Q. Doctor, before the deposition began you allowed  
7 me to look at your file which I'm now going to  
8 hand back to you --

9 A. Okay.

10 Q. -- and I have taken some documents out of that  
11 file that I'm going to have marked as exhibits  
12 and then ask you about.

13 But could you just hold that file up  
14 and let the jury see your file on Mr. Waskowski  
15 and who provided that file to you?

16 A. I assume it was the same group that sent him to  
17 me, MES. That's who my letters are addressed to.

18 MR. TEMROWSKI: So we don't have to  
19 waste time, why don't we go off the record and  
20 I'll have the court reporter mark the documents  
21 that I took out and then we'll go back on and  
22 I'll ask you the questions.

23 THE WITNESS: Okay.

24 VIDEOGRAPHER: Going off the record at  
25 1:47 PM.

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1 (A recess was taken).

2 VIDEOGRAPHER: We're back on the record  
3 at 1:51 PM.

4 BY MR. TEMROWSKI:

5 Q. Doctor, since Mr. Hewson began by questioning you  
6 about your credentials, your qualifications, I  
7 guess I'll begin there also.

8 You indicated that you're a clinical  
9 professor at Wayne State Medical School, correct?

10 A. Yes.

11 Q. Is that what you do full time?

12 A. No, not at all.

13 Q. You have no hospital affiliations?

14 A. Correct.

15 Q. Do you actually treat individuals who have been  
16 injured in automobile accidents?

17 A. Yes.

18 Q. And your specialty is physical medicine and  
19 rehabilitation, correct?

20 A. Yes.

21 Q. You are not an orthopedic surgeon?

22 A. Right.

23 Q. And do you perform surgery on individuals at all?

24 A. No.

25 Q. Have you ever performed a neck or a back surgery?

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1 A. No.

2 Q. Now, we've established that you've authored two  
3 reports?

4 A. Correct.

5 Q. And the first report was July 7, 2011 that you  
6 sent to MES?

7 A. Right.

8 Q. And that was prepared and sent to you -- sent by  
9 you to them on the day that you examined  
10 Mr. Waskowski?

11 A. Well, it was prepared the same day. We will --  
12 I'll have it typed out, but the next day I'm in  
13 the office, whatever that turned out to be, is  
14 when I -- I review them at home online, edit it  
15 and then the next business day, next time I'm in  
16 the office, it gets mailed out that day.

17 Q. Do you have that report in front of you?

18 A. Yes, I do.

19 Q. Take a look on the first page towards the bottom,  
20 you indicate that before this automobile  
21 collision occurred Mr. Waskowski didn't have  
22 these type of problems, correct?

23 A. Correct.

24 Q. And that before the automobile collision of  
25 December 23, 2009 he wasn't treating with any

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1 doctors, correct?

2 A. Right.

3 Q. Didn't undergo or need any medical testing or  
4 treatment?

5 A. Right.

6 Q. Was able to work?

7 A. Yes.

8 Q. And was under no limitations at all?

9 A. Correct.

10 Q. And in fact he was very healthy in general and  
11 took no medications at all before the automobile  
12 collision, correct?

13 A. Right.

14 Q. And Mr. Waskowski, if you now turn to Page 2, you  
15 indicated that he was employed as a road truck  
16 driver?

17 A. Right, over the road.

18 Q. And he'd drive up to a thousand miles a day?

19 A. Right.

20 Q. And that Mr. Waskowski has not worked since the  
21 automobile collision of 12-23-09?

22 A. Correct.

23 Q. You then performed your exam on Mr. Waskowski?

24 A. Right.

25 Q. But -- and authored this report?

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1 A. Right.

2 Q. But as you state two times in this report, you're  
3 not going to give an opinion on Mr. Waskowski's  
4 medical condition until you review the records?

5 A. Right.

6 Q. And as I understand it after this examination you  
7 were provided records which you have in front of  
8 you?

9 A. They were actually provided before. As I  
10 mentioned, I didn't have a chance to look at  
11 them, but yeah, they were provided concurrent.

12 Q. And that's what's in your file in front of you,  
13 correct?

14 A. Yes.

15 Q. And, as you've testified, you've reviewed all  
16 those records?

17 A. That's right.

18 Q. Because it was important to do so?

19 A. Right.

20 Q. Now, your second report, if you take a look at  
21 that because it's the report I'm going to go  
22 through now with you is dated July 11, 2011.

23 And again this report is sent to MES,  
24 correct?

25 A. Right.

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1 Q. In the second paragraph entitled "Record Review",  
2 you indicate -- and I'm going to quote it and  
3 read it, you wrote,

4 "Photographs presumably from this event  
5 show moderate damage to the front  
6 driver's side and mild damage to the  
7 rear driver's side of a small sedan."

8 Correct?

9 A. Right.

10 DEPOSITION EXHIBIT 3  
11 copy of two photographs  
12 WAS MARKED BY THE REPORTER  
13 FOR IDENTIFICATION.

14 Q. And in your file, and I'm going to now hand you  
15 what I've had marked as Deposition Exhibit 3, are  
16 those the photos that you reviewed and referred  
17 to?

18 A. Well, if you pulled them from here, then yes.

19 Q. Yes.

20 A. I mean, a year and a half later I don't have  
21 recollection, but if they were pulled from there,  
22 then yes, these are the ones I saw.

23 Q. And in your opinion is that moderate damage to a  
24 motor vehicle?

25 ~~MR. HEWSON: Objection, foundation.~~

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1 Doctor, to the extent you have an answer, go  
2 ahead.

3 MR. TEMROWSKI: Well, that's the  
4 doctor's own words.

5 MR. HEWSON: I understand, but I'm  
6 saying foundation. I don't think it's relevant;  
7 go ahead.

8 A. I said there was moderate to the front end, front  
9 driver's side, and yeah, I would call that  
10 moderate. I've certainly seen a whole lot more  
11 and a lot less and quite mild on the back.

12 BY MR. TEMROWSKI:

13 Q. Then if you look on Page 2 of your report you  
14 indicate that you reviewed records from a  
15 Dr. Donahue, correct?

16 A. Yes.

17 Q. And you indicated in your report that  
18 Dr. Donahue's name does not appear on an ABMS  
19 website?

20 A. Correct.

21 Q. What does that mean?

22 A. I mentioned earlier that there was 24 major  
23 specialties. They all sit under the umbrella  
24 organization called the ABMS, the American Board  
25 of Medical Specialties.



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1                   They have a website that you can put  
2                   someone's name in and see if they're board  
3                   certified in anything. Dr. Donahue -- at the  
4                   time -- this is only a year and a half ago, but  
5                   at the time I didn't know there was a way to do  
6                   the same thing, to look up for a D.O. He's an  
7                   osteopath, so I mention there he's not on the  
8                   ABMS website, but a lot of osteopaths are not  
9                   because they get certified through the  
10                  osteopathic boards. I said he though is a D.O.  
11                  I have since, probably soon after that because  
12                  it's been a while, I since have found there is a  
13                  way to look for the same thing.

14                  So if you were to tell me he's board  
15                  certified in orthopedic surgery, I consider those  
16                  equivalent, you know, the D.O. boards and the  
17                  ABMS boards.

18    Q.    Do you know Dr. Donahue?

19    A.    No.

20    Q.    Do you know what hospitals he's on staff at?

21    A.    No.

22    Q.    But you did review two reports that he authored,  
23            correct?

24    A.    Yes.

25    Q.    And those reports are dated August 19, 2010 and

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1 December 14, 2010, correct?

2 A. Right.

3 DEPOSITION EXHIBIT 4

4 reports dated 8-19-10 and 12-14-10

5 WAS MARKED BY THE REPORTER

6 FOR IDENTIFICATION.

7 Q. And they're in your file and I've had those  
8 pulled out and marked as Exhibit 4. I'm going to  
9 hand them to you.

10 A. Okay.

11 Q. And I'd like to start with the August 19, 2010  
12 report.

---

13 MR. HEWSON: I will object to both of  
14 these in that they are hearsay and if they're  
15 being admitted for the truth of the matter  
16 contained therein, there is no foundation.

17 Subject to that of course we'll take  
18 your answers.

---

19 BY MR. TEMROWSKI:

20 Q. Dr. Donahue in his report indicates that  
21 Mr. Waskowski was seen for a second opinion,  
22 correct, very top of the report, first sentence  
23 the 8-19-2010 --

24 A. Oh, I'm sorry I had the wrong one in my hand.  
25 Yes, second opinion, right.

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1 Q. And it talks about the motor vehicle accident of  
2 December 23, 2009, correct?

3 A. Yes.

4 Q. And it indicates that Mr. Waskowski was  
5 complaining to [sic] pain to various parts of his  
6 body, correct?

7 A. Right.

8 Q. Including his shoulder and his back?

9 A. Ah, let's see. Cervical spine, lumbar spine,  
10 left shoulder and left leg.

11 Q. And Dr. Donahue in his report that you have, he  
12 performed a physical examination upon  
13 Mr. Waskowski, didn't he?

14 A. Yes.

15 MR. HEWSON: Objection, foundation; go  
16 ahead.

17 BY MR. TEMROWSKI:

18 Q. And that physical examination is -- the findings  
19 were different than what you found, aren't  
20 they --

21 A. Yes.

22 Q. -- when you examined Mr. Waskowski?

23 A. They are.

24 Q. And in fact there are several -- what would you  
25 call them -- abnormalities that he found when he

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1 examined Mr. Waskowski?

2 A. Abnormal physical findings.

3 Q. And there's -- at the bottom of the page it  
4 discusses the MRI, correct?

5 A. Yes.

6 Q. And would you just read from that report what the  
7 MRI indicates?

8 A. He writes that the MRI of the cervical spine  
9 demonstrates basically ruptured disc, herniated  
10 nucleus pulposus greatest at C4-5 and C5-6.

11 Further he says there is another  
12 ruptured disc in the low back between L5 and S1.

13 Q. And he arrives at an impression, doesn't he?

14 A. Yes.

15 Q. And would you read what that states?

16 MR. HEWSON: Objection, same thing. Go  
17 ahead, doctor.

18 A. He has -- the impression was involved in the  
19 accident, suffering to the cervical and lumbar  
20 spine, but then more specifically the same three  
21 disks he just mentioned from the MRI scan.

22 BY MR. TEMROWSKI:

23 Q. And then Dr. Donahue arrived at a plan for  
24 treatment, correct?

25 A. Yes.

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1 Q. And in fact his plan for treatment was to have  
2 Mr. Waskowski follow up with Dr. Glowacki for  
3 injections of the said areas with epidural  
4 steroid, is that true?

5 A. That's what he wrote.

6 Q. Then, doctor, if you could look at the other  
7 report that Dr. Donahue authored, the report  
8 dated December 14, 2010, in the very last  
9 paragraph Dr. Donahue discusses --

10 A. Sorry, of the second page?

11 Q. Of the second page?

12 A. Okay, yep.

13 Q. And Dr. Donahue discusses a possible surgical  
14 intervention, isn't that true?

15 A. He does.

16 Q. And would you please read to the jury what  
17 Dr. Donahue wrote regarding a possible surgical  
18 intervention?

19 MR. HEWSON: Objection, hearsay. Go  
20 ahead.

21 A. He once again talked about these injections that  
22 we mentioned from the first visit, but then he  
23 said if he does not have significant improvement  
24 from those injections we may discuss some  
25 surgical intervention which would include

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1 possible disk removal versus fusion in the low  
2 back and a fusion in the neck.

3 I mean, technically other words, but  
4 that's what he meant.

5 BY MR. TEMROWSKI:

6 Q. And again, doctor, Dr. Donahue is an orthopedic  
7 surgeon and you are not, correct?

8 MR. HEWSON: Objection, foundation. Go  
9 ahead.

10 A. Well, I'll assume he's board certified. If you  
11 know that or not, but I assume he's board  
12 certified, so I'll say yes, he's an orthopedic  
13 surgeon and I am not.

14 BY MR. TEMROWSKI:

15 Q. Okay. Now, I've already pulled from your records  
16 Dr. Zamorano's report that you and Mr Hewson  
17 talked about here.

18 A. Briefly.

19 MR. HEWSON: Same objection regarding  
20 hearsay and foundation. Go ahead.

21 BY MR. TEMROWSKI:

22 Q. And, again, just so I'm clear, doctor, you did  
23 review these reports, didn't you?

24 A. Yes.

25 Q. And they're in your file?

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1 A. Yes.

2 Q. And you indicated that -- I'm quoting you and if  
3 it's inaccurate, please let me know -- but I  
4 believe you testified that these reports and  
5 records give you insight as to what others have  
6 found?

7 A. Right.

8 DEPOSITION EXHIBIT 5  
9 report dated 3-18-11  
10 WAS MARKED BY THE REPORTER  
11 FOR IDENTIFICATION.

12 Q. So now we have Dr. Zamorano's report which I've  
13 had marked and handing you as Exhibit 5. And if  
14 you could please look on Page 3 of her report  
15 regarding Mr. Waskowski --

16 A. Okay.

17 Q. -- there is a heading entitled "Medical  
18 Diagnosis", do you see that?

19 A. Diagnostics, yeah, testing.

20 Q. And would you please read to the jury what that  
21 states?

22 A. The whole paragraph?

23 Q. That paragraph.

24 A. MRI of the left shoulder on September 28, 2010  
25 reports a degree of rotator cuff strain and small

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1 tears in the cartilage of the shoulder. There  
2 are some arthritis claims as well.

3 MRI of the low back, the lumbar spine,  
4 shows disk herniations at two levels, L4-5, L5-S1  
5 and then MRI of the neck shows multiple disk  
6 herniations, she mentions two levels, C4 through  
7 C6 and then that was really it for significant  
8 findings.

9 Q. Okay, and then right below that there is a  
10 section entitled "Assessment"?

11 A. Yes.

12 Q. And would you please read what Dr. Zamorano wrote  
13 there regarding Mr. Waskowski?

14 A. She said he was involved in an MV -- a car  
15 accident which resulted in neck pain from disk  
16 herniations, low back pain from two disk  
17 herniations and left shoulder pain from these  
18 cartilage tears.

19 She also mentioned dizziness which I  
20 didn't really deal with.

21 Q. And then right below that on her report is a  
22 section entitled "Medical Decision Making",  
23 correct?

24 A. Yes.

25 Q. And isn't it true, doctor, that in that section



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1 of her report Dr. Zamorano wanted Mr. Waskowski  
2 to undergo additional MRI testing?

3 MR. HEWSON: Objection, foundation. Go  
4 ahead.

5 A. For the brain, for the dizziness, but yeah.

6 BY MR. TEMROWSKI:

7 Q. And she also recommended that he be fitted for a  
8 neck brace and a back brace?

9 A. Correct.

10 Q. Now, going back to your second report on Page 2,  
11 you evidently have in your file and you reviewed  
12 other medical reports that were performed by  
13 other physicians who did independent medical  
14 examinations on Mr. Waskowski, correct?

15 A. I think there was just one. That second from  
16 last paragraph says orthopedic IME. I think that  
17 was the only other one, only one.

18 Q. Okay, well, we'll get --

19 A. Is there another?

20 DEPOSITION EXHIBIT 6  
21 reports dated 7-23-10 and 9-3-10  
22 WAS MARKED BY THE REPORTER  
23 FOR IDENTIFICATION.

24 Q. Well, yes, and we'll get to that in one second.  
25 Again, I pulled these documents from your file.

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1 They've been marked as Exhibit 6.

2 I'm going to hand those to you and  
3 those are reports from a Dr. Higginbotham,  
4 correct?

5 A. Yeah, that's right.

6 Q. And they were in your file?

7 A. Yes.

8 Q. And you looked at them?

9 A. Yes.

10 Q. And Dr. Higginbotham is an orthopedic surgeon,  
11 correct?

12 A. Yes.

13 Q. And he performed an independent medical  
14 examination on Mr. Waskowski, correct?

15 A. Yes.

16 Q. And Dr. Higginbotham authored two different  
17 reports, one is dated July 23, 2010 and the other  
18 September 3, 2010, correct?

19 A. Yes.

20 Q. If you would look at the July 23, 2010 report on  
21 Page 4 at the bottom there's a heading called  
22 "Diagnostic Impression", correct?

23 A. Yes.

24 Q. And then if you flip the page to Page 5 the  
25 second paragraph, would you read to the jury the

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1 first sentence of the second paragraph what  
2 Dr. Higginbotham wrote after he examined  
3 Mr. Waskowski?

4 ~~MR. HEWSON: Objection, hearsay. Go~~  
5 ~~ahead.~~

6 A. It would be appropriate for him, the patient, to  
7 have a course of an epidural steroid injection to  
8 see if this would be beneficial for him.

9 BY MR. TEMROWSKI:

10 Q. And then if you would please look at --

11 A. Now, you know, let me just be fair here and you  
12 asked me to read the first sentence, but there's  
13 a pretty important point in the next sentence  
14 which he says this could be useful as a  
15 diagnostic test as well as a therapeutic one,  
16 meaning diagnostic if his pain were taken care of  
17 that might be a useful procedure.

18 So he wasn't saying that he had a  
19 definite reason for the epidural, possibly to see  
20 if there was an actual condition.

21 Q. Okay, and then if you would look at  
22 Dr. Higginbotham's second report that he wrote,  
23 and -- you've got that in front of you, correct?

24 A. Yes.

25 Q. And the very first sentence in Dr. Higginbotham's

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1 independent IME report of September 3, 2010  
2 states, and I'm quoting, "I had an opportunity to  
3 review actual images of the MRI of the cervical  
4 spine on Jaroslaw Waskowski", correct?

5 A. Yes.

6 Q. And Dr. Higginbotham is an orthopedic surgeon,  
7 correct?

8 A. He is.

9 Q. And in the second paragraph down from that would  
10 you please read to the jury what Dr. Higginbotham  
11 wrote in his report after he personally reviewed  
12 the actual MRIs?

13 ~~MR. HEWSON: Objection, foundation,~~  
14 ~~hearsay. Go ahead.~~

15 A. He said that he shows multiple level disk  
16 herniation at three levels in the neck and two  
17 levels in the low back.

18 Was that all from that report you were  
19 going to ask me about?

20 BY MR. TEMROWSKI:

21 Q. That's all I was going to ask you.

22 A. Because, again, there's context here and there's  
23 a lot more in that report that plays into this.

24 MR. HEWSON: I'll ask you about it.

25 THE WITNESS: Oh, okay.

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1 BY MR. TEMROWSKI:

2 Q. But that is what he wrote?

3 A. That's what he wrote, that's part of what he  
4 wrote.

5 DEPOSITION EXHIBIT 7  
6 addendum to report dated 2-18-11  
7 and addendum to report dated 11-16-10  
8 WAS MARKED BY THE REPORTER  
9 FOR IDENTIFICATION.

10 Q. Now, when you were kind enough to let me look at  
11 your file, on the very top of your file that I  
12 pulled out I've had marked as Exhibit 7 is  
13 actually two reports from another doctor who  
14 performed an independent medical examination on  
15 Mr. Waskowski and that is a Dr. Zachary Endress  
16 who again is an orthopedic surgeon.

17 MR. HEWSON: Objection, foundation. Go  
18 ahead.

19 A. You know what, I did -- the last sentence of the  
20 paragraph in my report says another orthopedic  
21 evaluation agreed with ESI. This may shorten  
22 that line of -- agreed with ESI.

23 BY MR. TEMROWSKI:

24 Q. Well, doctor, again I've had Dr. Endress' two  
25 reports that were in your file marked as Exhibit

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1 7, I'm going to hand those to you.

2 Do you have any reason to doubt that

3 Dr. Endress is an orthopedic surgeon?

4 A. No.

5 Q. Please take a look at Dr. Endress' independent

6 IME report dated October 25, 2010.

7 A. The only two you handed me -- the actual

8 evaluation was done on November 16 of 2010 -- oh,

9 no, that was an addendum, so I guess I'm missing

10 one.

11 Q. No, no, that's the one I want to ask you about.

12 A. Okay.

13 Q. The addendum and that is what date?

14 A. November 16, 2010.

15 Q. Okay, could I just see that a minute? Okay, this

16 is the one I wanted to ask you about.

17 For starters, could you please tell the

18 ladies and gentlemen of the jury who did

19 Dr. Endress write that report to?

20 A. State Farm Insurance.

21 Q. And is there a particular adjuster?

22 A. Terri Page.

23 Q. And in this report that Dr. Endress wrote on

24 November 16, 2010 he is responding to several

25 questions that the adjuster Terri Page asked

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1 Dr. Endress, correct? Take a look at it.

2 A. I assume so, yes.

3 Q. Would you please, doctor, read for the jury the  
4 first question that was asked by the claims  
5 adjuster and what Dr. Endress' answer was to the  
6 first question?

7 ~~MR. HEWSON: Objection, foundation,~~  
8 ~~hearsay Go ahead.~~

9 A. They basically asked what's the diagnosis. His  
10 answer was herniated cervical and lumbar disks.

11 BY MR. TEMROWSKI:

12 Q. And please read the second question that was  
13 asked and what his answer was?

14 ~~MR. HEWSON: Same objection.~~

15 A. It says what are your diagnoses of Mr. Waskowski.  
16 He gave the same answer, disk herniation both the  
17 neck and low back and then he goes on to say he  
18 agrees with trying these epidurals.

19 BY MR. TEMROWSKI:

20 Q. And what is the third question that was asked him  
21 and what was his answer?

22 A. Has he reached pre-injury status, answer was no.

23 Q. And what was the fifth question that was asked  
24 and what was his answer?

25 A. Is he yet able to return to pre-accident activity

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1 levels including at work, and he said no, not  
2 yet.

3 Q. And last but not least would you read to the jury  
4 what was the sixth question that was asked and  
5 what was his answer?

6 A. They asked about replacement services, household  
7 assistance, chores. He said I think he does need  
8 help with laundry, meal preparation and  
9 landscaping, outdoor activities.

10 Q. And then you have another letter there?

11 A. Oh, yeah.

12 Q. Correct?

13 A. Yes.

14 Q. And, again, that is a letter dated February 18,  
15 2011?

16 A. Right.

17 Q. And, again, that report is signed by Dr. Endress  
18 who did the IME on Mr. Waskowski?

19 ~~MR. HEWSON: Objection same, same~~  
20 ~~objection, hearsay. Go ahead.~~

21 A. It's not signed by him, but authorized signature  
22 by him, yes. There's some initials below who  
23 signed it, but that's all right. He generated  
24 the report.

25 BY MR. TEMROWSKI:



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1 Q. And you don't doubt that, do you?

2 A. Correct.

3 Q. And, again, would you tell the ladies and  
4 gentlemen of the jury who was this report sent  
5 to?

6 A. Same, State Farm and Terri Page.

7 Q. And Dr. Endress writes to Ms. Page -- and correct  
8 me if I'm not reading it right -- "I have  
9 reviewed the additional records that you provided  
10 to me regarding Mr. Waskowski," correct?

11 A. Yes.

12 Q. "As I mentioned in my original report, I think  
13 that he does have loss of some services including  
14 laundry, meal preparation and yard work as well  
15 as landscaping activities"?

16 A. That's what he wrote.

17 Q. And that was on February 18, 2011?

18 A. Yes.

19 Q. Just a few follow-up questions and I'm almost  
20 done.

21 A. Sure.

22 Q. But I believe that you testified to Mr. Hewson  
23 and indicated that in your experience that  
24 physical therapy should only be given to an  
25 individual for eight or nine visits for about

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1 three weeks, is that true?

2 A. That was for a strain.

3 Q. For a strain?

4 A. Ten, up to 10 visits, 10 or 12.

5 Q. What about through for a herniated disk?

6 A. Herniated disk without radiculopathy, without a  
7 pinched nerve, would be possibly six or even  
8 eight weeks.

9 Q. At most?

10 A. Typically at most if all goes well.

11 Q. And you indicated when Mr. Hewson asked you a  
12 question about an injury -- I guess he was asking  
13 about what Dr. Glowacki said about Mr. Waskowski  
14 that Dr. Glowacki believed that because of his  
15 injuries Mr. Waskowski would have pain for the  
16 rest of his life?

17 A. Right.

18 Q. And you don't agree with that?

19 A. Correct.

20 Q. Well, have you ever, doctor, in your experience  
21 of dealing with people who have neck and back  
22 injuries and specifically herniated disks, have  
23 you ever heard of someone having problems for the  
24 rest of their life because of a herniated disk?

25 A. What I actually said before to Mr. Hewson was

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1           there's no known musculoskeletal condition, again  
2           not cancer or something, that explains pain for  
3           the rest of your life.

4                       I mention that if someone told me 20  
5           years from now I've had pain since I met you 20  
6           years ago, there's no way to say yes or no to  
7           that because it can't be measured.

8                       There's no way to refute or confirm  
9           that somebody actually has pain. The question is  
10          what is the cause of that pain, is there  
11          something explainable causing that pain in the  
12          organic world as opposed to something  
13          non-organic.

14    Q.    Now, if I understand your testimony correctly  
15           when you were asked about your diagnosis for  
16           Mr. Waskowski you indicated that there was no  
17           condition found and that he was a malingerer?

18    A.    When I examined him --

19    Q.    Is that your diagnosis of him?

20    A.    That is my -- and remains my diagnosis even with  
21           the other records I just looked at, yes.

22    Q.    And is it your opinion that if a person did have  
23           herniated disks in their neck and back in your  
24           opinion that that individual would not need  
25           attendant care?

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1 A. From herniated disks they would not, no,  
2 absolutely not. If that person went through a  
3 fusion I mentioned earlier that post-op they  
4 would need temporary attendant care, but not for  
5 the condition itself.

6 Q. So absent a surgery, no fusion, they don't need  
7 attendant care at all?

8 A. For a herniated disk?

9 Q. For a herniated disk.

10 A. No. You're asking for attendant care, not  
11 household assistance?

12 Q. No, I'm asking only about attendant care.

13 A. Correct, that's my opinion.

14 Q. Now, doctor, what injuries do you believe  
15 Mr. Waskowski suffered in the automobile  
16 collision of December 23, 2009?

~~17 MR. HEWSON: Objection, foundation. Go  
18 ahead, please.~~

19 A. Well, what I can say is I examined him a year and  
20 a half later, so when I was asked about looking  
21 at records, that's when I mentioned I see what  
22 other people were looking at and what their  
23 conclusions they came to.

24 I look for things that would  
25 objectively document, let's say, exacerbation of

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1 pre-existing cervical and lumbar spine  
2 degeneration as a possibility, or herniated disk.  
3 These were degenerative disks, but they can be  
4 exacerbated.

5 There was nothing in any of  
6 Dr. Glowacki's notes, many of which were  
7 illegible, and nothing in the independent  
8 evaluations you mentioned from the two different  
9 physicians that to me documents the pattern of  
10 findings that I expect to find with those  
11 conditions.

12 So that's why my conclusion was there's  
13 nothing to suggest an impairment, nothing to  
14 suggest an actual condition.

15 BY MR. TEMROWSKI:

16 Q. And now, doctor, you're aware that Mr. Waskowski  
17 underwent MRI testing not once but two times?

18 A. Right.

19 Q. First time at Macomb MRI and then quite a while  
20 later at Oakland MRI, correct?

21 A. Right.

22 Q. And you've got those reports in your file?

23 A. Right. I also looked at some of those images,  
24 not all of them.

25 Q. And would you agree with me, doctor, that the

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1 written reports from both of the facilities that  
2 performed the MRI testing on Mr. Waskowski's neck  
3 and back clearly wrote down by the radiologists  
4 that read them herniated disks?

5 MR. HEWSON: I'm going to object to the  
6 foundation, it's a compound question. To the  
7 extent you can, please answer.

8 A. The reports said herniated disks, yes, both  
9 reports both times -- I mean both places.

10 BY MR. TEMROWSKI:

11 Q. We agree that that's what they say?

12 A. That's what they say.

13 Q. And in the case of Mr. Waskowski you commented to  
14 Mr. Hewson again about Dr. Glowacki's diagnosis  
15 of fractures, but as I understand it you yourself  
16 never actually saw the actual bone scan, only the  
17 written report?

18 A. Right.

19 Q. And you never actually reviewed with your own  
20 eyes the x-rays, you only looked at the report?

21 A. Right.

22 Q. As opposed to these other doctors that we talked  
23 about who are treating doctors of Mr. Waskowski,  
24 you performed a one-time exam, correct?

25 A. Correct.

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1 Q. And that exam was done on July 7, 2011?

2 A. Right.

3 Q. And is it true that all of the opinions that  
4 you're giving this jury today are based upon that  
5 one-time exam and your review of the records?

6 A. Right, along with my experience and general  
7 knowledge, but yes, for Mr. Waskowski only those.

8 Q. You don't agree with Dr. Glowacki?

9 A. In general, correct.

10 Q. You don't agree with Dr. Zamorano?

11 MR. HEWSON: I'm going to object.

12 There's no foundation for that, but go ahead.

13 MR. TEMROWSKI: Well, let me rephrase  
14 it then.

15 BY MR. TEMROWSKI:

16 Q. Do you agree with Dr. Zamorano's assessment of  
17 Mr. Waskowski?

18 MR. HEWSON: Object, there's no  
19 foundation that she made such an assessment, but  
20 subject to that you can answer.

21 A. I think the only comment I made about her input  
22 was the EMG testing.

23 BY MR. TEMROWSKI:

24 Q. Do you agree with Dr. Donahue's assessment of  
25 Mr. Waskowski?

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1 A. If he is saying that his exam found symptomatic  
2 clinically relevant disk herniations, I disagree  
3 with that.

4 Q. Do you believe that Mr. Waskowski ever needed  
5 household assistance?

6 MR. HEWSON: Objection, foundation,  
7 relevance. Go ahead.

8 A. Well, when I examined him certainly not. Based  
9 on the records I reviewed no, I do not think so.

10 BY MR. TEMROWSKI:

11 Q. So you don't agree with Dr. Endress who performed  
12 an independent medical examination on him?

13 A. I do not.

14 Q. And I take it you don't agree or don't believe  
15 that Mr. Waskowski needed or ever needed  
16 attendant care?

17 A. Not attendant care, certainly not.

18 Q. Is your opinions that you're giving to this jury  
19 today limited to the date of your examination of  
20 Mr. Waskowski?

21 In other words, you didn't see him  
22 before July 11, 2011?

23 A. July 7, but correct.

24 Q. And you don't know what his condition was like  
25 then, correct?



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1 A. Well, what I can give opinions about is from  
2 direct observation of him that one date, but of  
3 course the file is where I got the rest of my  
4 information.

5 Q. Now, I'd like to finish up by just asking you  
6 we've established that you performed a one-time  
7 independent exam and that was done at whose  
8 request?

9 A. MES, secondarily State Farm apparently.

10 Q. And would you please tell the ladies and  
11 gentlemen of the jury who exactly is this MES?

12 A. I consider them kind of an outfit that brokers  
13 these exams. They will have physicians go into  
14 their own offices to perform these exams and I  
15 believe in the case of MES it's all defense side.

16 I did that for a very short time when I  
17 went into my own private practice in '99 for  
18 about a year, but otherwise they would send  
19 people to me, again sort of brokering them  
20 through -- I don't know if it's State Farm -- in  
21 this case State Farm. I'm not sure who else they  
22 might deal with.

23 Q. And you've been working with MES for how long?

24 A. I've believe since '99 at least to some extent.

25 Q. And what exactly is your legal relationship to

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1 MES?

2 A. None.

3 Q. Are you an independent contractor?

4 A. Yes, there's none of these companies that I go  
5 into their office or have any agreement with  
6 other than I'm happy to take patients from them  
7 and -- or, you know, referrals from them and I  
8 assume they -- well, I think they're the ones,  
9 for example, it doesn't come straight from State  
10 Farm.

11 I think MES or people like them will  
12 copy the records and do things like that.

13 Q. And in the case of Mr. Waskowski did you generate  
14 a fee that was charged for your exam of him and  
15 your review of the records?

16 A. Sure.

17 Q. And would you please tell us what was your fee?

18 A. The fee last year was \$740 for the exam which  
19 includes up to 15 minutes of record review and  
20 the exam and the report.

21 And then the record review I can  
22 probably tell you, because I charge that at the  
23 same rate, hourly rate, but in 15-minute  
24 increments, and this was an hour and  
25 three-quarters, so an hour and three-quarters,

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1 one and three-quarters times \$740, what is that,  
2 another \$1,300 and something maybe on top of  
3 that, so a little over \$2,000 total.

4 Q. And who paid you that fee?

5 A. It usually would come from MES itself.

6 Q. And in addition to that fee did MES charge a fee?

7 MR. HEWSON: Objection, foundation. Go  
8 ahead.

9 A. I have no idea, but I assume they're in business  
10 to also -- they can't stay in business without  
11 charging a fee, so I don't know what they might  
12 charge on top of that.

13 It wouldn't make good business sense  
14 for them to just pay me whatever State Farm pays  
15 them, so I assume they get a fee for what they  
16 do.

17 BY MR. TEMROWSKI:

18 Q. And what about for today's deposition, what is  
19 your fee to that?

20 A. A new year, so I went up \$20, so it's \$760 per  
21 hour now.

22 Q. \$760 per hour?

23 A. Right, for the deposition.

24 Q. And is MES paying that fee?

25 A. I don't know, I don't think so, I'm not sure.

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1 I'm not sure where the request for the deposition  
2 came from, if Mr. Hewson -- I just don't know.  
3 Ultimately I would assume it gets paid by the  
4 insurance company.

5 Q. State Farm?

6 A. By State Farm.

7 Q. And this examination that you actually performed  
8 -- I'm not talking about the record review -- the  
9 exam of Mr. Waskowski, how long did that last?

10 A. Face to face, about 30 minutes.

11 Q. And, doctor, what percent of your -- what shall  
12 we call it -- your livelihood is devoted to doing  
13 these types of examinations?

---

14 MR. HEWSON: I'm going to object to the  
15 foundation unless you're asking just about State  
16 Farm. Any other inquiries are irrelevant, but  
17 subject to that you can answer.

---

18 A. I mentioned earlier that about 60 percent of my  
19 practice is treatment and the other remainder are  
20 evaluations, evaluation only.

21 BY MR. TEMROWSKI:

22 Q. And have you ever done these types of evaluations  
23 in the past for State Farm?

24 A. Oh, yeah.

25 Q. How many?

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1 A. I don't keep track of numbers by provider or by  
2 insurance company. My sense is that State Farm,  
3 of all the people who send folks to me is the  
4 single biggest sender of these evaluations, not  
5 majority but the plurality.

6 Again, I don't have a way of actually  
7 counting them.

8 Q. And on this last question, I want to make it  
9 perfectly clear that I'm not inquiring about your  
10 income from your private practice, but what was  
11 your income last year for performing these  
12 one-time examinations.

13 MR. HEWSON: Objection, foundation and  
14 if it doesn't relate to State Farm it's  
15 irrelevant. Subject to that you can answer.

16 A. Well, I've been asked that many times and the  
17 problem is I can't really tell and I don't have a  
18 good way of keeping track other than going  
19 through my records one person by one person which  
20 I'm not going to do.

21 The reason is because when I get people  
22 from State Farm for these evaluations or from  
23 other insurance companies I also get people from  
24 them for treatment, and so when I get a statement  
25 at the end of the year, you know, the 1099 at the

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1 end of the year, it includes all of those.

2 And so -- and they don't separate them  
3 out, so there's really no good way for me to  
4 separate it, there's no possible way for me to  
5 separate that out, so I really don't know.

6 BY MR. TEMROWSKI:

7 Q. How many of these exams would you estimate that  
8 you performed this year?

9 A. Oh, boy. Again, I don't keep -- I know I'm  
10 usually asked what percent of my practice is  
11 this. That's why I know ballpark in the 40  
12 percent, 35, 40 percent. Actual number-wise I  
13 really haven't been asked -- or not asked that  
14 very often so I don't have that number.

15 I know it's about 40 percent.

16 Q. Well, if you had to give it your best shot, how  
17 many individuals would you say in the year 2012  
18 you examined like you did Mr. Waskowski?

19 A. Again, I don't have a good way to even estimate  
20 that. Ballpark, a few hundred, I don't know,  
21 yeah.

22 MR. TEMROWSKI: Okay, thank you, I have  
23 no other questions.

24 MR. HEWSON: I have some to follow up.

25 RE-EXAMINATION

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1 BY MR. HEWSON:

2 Q. Is there anything on Exhibit 4 that indicates  
3 that Dr. Donahue is board certified? Does that  
4 show up anywhere in any of his reports that  
5 indicates he's board certified in any specialty?

6 A. No, but not everyone who is board certified says  
7 so on their letterhead, but again if I were at my  
8 home computer I could check in one minute, but  
9 there's nothing on these files that says so.

10 Q. My point is, you were just asking to look at the  
11 records.

12 A. Yeah.

13 Q. And there's nothing in here whether he was or not  
14 that indicates to you that Dr. Donahue is board  
15 certified?

16 A. That's correct.

17 Q. And when you checked the American Board of  
18 Medical Specialties website you found that he's  
19 not board -- or he's not listed on the board for  
20 that particular area, am I correct in that?

21 A. He's not listed on ABMS. Now, keep in mind  
22 that's the umbrella organization for M.D.s. Some  
23 D.O.s will get board certified on the M.D. side  
24 for various political and other reasons.

25 The D.O. universe has its own set of

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1 board certifications, so it's the American Board  
2 of -- oh, of osteopathic PM&R, of osteopathic  
3 orthopedic medicine, and again I could check now  
4 if he's board certified.

5 And if he is, from the osteopathic side  
6 I take that as full scale as if it were on the  
7 ABMS side for an M.D. or a D.O. on the M.D. side.

8 Q. Sure.

9 A. But I just don't know.

10 Q. I understand. My point is, apparently we're not  
11 going to hear from Dr. Donahue himself so my  
12 question is from the documents you have there is  
13 no way of determining that, even when you did  
14 your own investigation, is that a correct  
15 statement?

16 A. Well, I don't know. There might have been a way  
17 back a year and a half ago for me to check the  
18 D.O. website, but I didn't know about it then.

19 I've done it routinely for at least a  
20 year now, but -- so I just don't know.

21 Q. Okay. The reports -- the report of August 19,  
22 2010 from Dr. Donahue is not authored to any  
23 particular individual, is it?

24 A. It's not authored, it just says that it's a  
25 second opinion from Dr. Glowacki.



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1 Q. From Dr. Glowacki. The report of December 14,  
2 2010, who's that one sent to?

3 A. A Mr. Temrowski.

4 Q. And, sir, on Page 2 of your report of July 11,  
5 you found something particular in relationship to  
6 Dr. Donahue's report, did you not?

7 A. On July 11, sorry.

8 Q. Yes. On the third line of your report.

9 A. I said the exam recorded -- is that what you  
10 mean?

11 Q. Yes, sir.

12 A. The exam recorded the second date was identical,  
13 the physical examination, pertinent findings, was  
14 identical in verbatim fashion to the only other  
15 visit -- oh, that was the first day.

16 The history -- the exam on 8-19-10 was  
17 identical to 12-14-10.

18 Q. Identical, is that significant?

19 A. Well, these were done four months apart and every  
20 pertinent finding, again was word for word the  
21 same. What I said was that's a medical  
22 impossibility.

23 Even if someone has a ruptured disk or  
24 a pinched nerve or something, it just doesn't  
25 happen that the exam is identical even a week

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1           apart or a couple of days apart necessarily.

2                       So, yeah, to me that's relevant in that  
3           it's hard to lay much credibility on that  
4           examination when findings are exactly the same.

5   Q.   Now, Dr. Zamorano, you were asked about  
6       Dr. Zamorano. Did she make a diagnosis?

7   A.   I didn't see an actual diagnosis in her report,  
8       no.

9   Q.   So really there's no diagnosis for you to  
10       disagree with?

11   A.   Right.

12   Q.   And there were some interesting issues that arose  
13       from her report relative to her charges, correct?

14   A.   Yes.

15   Q.   And what was your concern there?

16   A.   Well, I just listed what she charged, for example  
17       for the EMG --

18   Q.   Yes, sir.

19   A.   -- she did it for the arms and legs, and her bill  
20       was \$8,000. When I -- it's rarely necessary to  
21       do all four limbs for an EMG, but when I do that,  
22       and when I use the State of Michigan Work Comp  
23       Guidelines, they have a pay schedule, it's about  
24       -- if I remember right -- about \$1,250, \$1,250  
25       reimbursement.

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1 Q. For all four limbs?

2 A. For all four limbs, so I said it's about six or  
3 seven times what the State of Michigan would  
4 allow, you know, etc.

5 Q. Now, you also note that she claims there's 4 out  
6 of 5 strength throughout all four limbs. Could  
7 you tell the jury in ranking strength what 4 out  
8 of 5 means or what the general ranking system is?

9 A. It's 0 through 5, 5 is normal. 4 is mild to  
10 moderate weakness so just what it sounds like.

11 You know, I can resist -- the person  
12 can resist against me, but I can overcome them,  
13 you know, somewhat. She listed the exact same  
14 strength or weakness 4 in every muscle she  
15 tested, arms, legs.

16 Once again, that's a medical  
17 impossibility. That's just not the way things  
18 work and, you know, I'm not sure why she listed  
19 4. Either -- there's a lot of possible reasons,  
20 but it's not possible what she listed.

21 Q. And you had a concern relative to the charges she  
22 was attempting to impose for a lumber corset, is  
23 that correct?

24 A. Well, yeah. She apparently dispensed a corset  
25 from her office.

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1 Q. What did she charge for that?

2 A. \$2,000.

3 Q. How does that factor in in your knowledge of what  
4 those things are supposed to be charged at?

5 A. From what I've seen, both off the shelf and for  
6 other invoices about 20 times, \$100 or in that  
7 ballpark, a little less, a little more, but about  
8 20 times to give somebody a corset out of your  
9 office.

10 Q. Are you supposed to do that? Are you supposed to  
11 provide DME out of your own office?

12 A. Well, people who do so would argue it's legal and  
13 it is legal in certain settings, but it's also  
14 illegal in other settings because of the  
15 potential conflict of interest in dispensing  
16 medications from your office, dispensing DME from  
17 your office or doing PT out of your office.

18 Any federally-funded patient, have  
19 addressed very much the medical and ethical  
20 conflict that that potentially leads to. And so  
21 it's illegal in those settings.

22 Q. Now, my brother counsel showed you  
23 Dr. Higginbotham's reports from July 23, 2010 and  
24 I believe his follow-up report from September 3,  
25 2010, correct?

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1 A. Right.

2 Q. There were things that you were asked basically  
3 to ignore in the findings from Dr. Higginbotham,  
4 isn't that true?

5 A. No, he didn't ask me to ignore them. He just  
6 didn't ask me about it.

7 Q. All right. Well, let me ask you about this  
8 symptom amplification issue. Do you remember  
9 discussing that? Let me show you Exhibit 6.

10 Do you remember discussing that in your  
11 report of July 11, 2011?

12 A. I believe I did, yes. Did I?

13 Q. Second to the last paragraph.

14 A. Yes.

15 Q. Could you take a look at the report and share  
16 with the jury what Dr. Higginbotham's concerns  
17 apparently were relative to symptom  
18 magnification?

19 A. Can you give me a hint where?

20 Q. I think -- I believe it's in the --

21 A. Oh, here we go. So Page 5, last paragraph, "I  
22 believe his presentation of being incapacitated  
23 to the point of requiring attendant care is  
24 symptom amplification" he says.

25 He appears to be capable of caring for

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1           himself, etc.

2       Q.   Does Dr. Higginbotham say that any attendant care  
3           should be ordered for Mr. Waskowski?

4       A.   No, he says no.

5       Q.   How does symptom magnification defined by  
6           Dr. Higginbotham interact, if it does, with your  
7           finding of malingering?

8                       How do those two things correlate, if  
9           they do?

10      A.   Well, symptom magnification is a -- if you will,  
11           a manifestation of malingering. It's one of  
12           those things where like I mentioned before, I'm  
13           going to magnify my symptom of aching because I  
14           have a cold so somebody else gets me the glass of  
15           orange juice.

16                       But when that becomes the primary  
17           behavior and it's done in the conscious way,  
18           which my examination clearly pointed out was very  
19           conscious, that becomes a diagnosis of  
20           malingering.

21      Q.   Now, there was discussion of epidural steroid  
22           injections as a possible diagnostic or  
23           therapeutic approach to Mr. Waskowski's  
24           complaints, is that correct?

25      A.   That was.

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1 Q. Could you explain to the jury what a diagnostic  
2 epidural steroid injection is as opposed to a  
3 therapeutic one, if you know the difference?

4 A. Well, I do and one would have a hard time finding  
5 support for the idea of a diagnostic epidural.  
6 It's an invasive procedure that carries potential  
7 risks. I mean, overall they're fairly safe.  
8 Unfortunately we're hearing about dozens of  
9 deaths from -- you know, it's not the typical  
10 epidurals with this fungus, but nonetheless  
11 potential complications or side effects.

12 And it really should be done, if you  
13 look at organizations that oversee or deal with  
14 this, they talk about you have to have actual  
15 radiculopathy.

16 Just symptoms is not enough and -- we  
17 haven't talked about this so far, but in terms of  
18 epidurals, they were never indicated in  
19 Mr. Waskowski for any stretch -- by any stretch  
20 of the medical imagination if you go by the  
21 guidelines that these organizations print, which  
22 is it has to be pinched nerve kind of pain.

23 At no pain -- and not just pain, not  
24 just symptoms, but there has to be some support  
25 for an actual radiculopathy, reflex or something

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1 that's dropped or atrophy or something.

2 None of that ever occurred in  
3 Mr. Waskowski. Nobody ever documented an  
4 abnormal neurologic exam. So as another point,  
5 not just me but guidelines, nationally published  
6 guidelines, would disagree that epidurals were  
7 warranted.

8 Q. Dr. Higginbotham also suggested in that  
9 diagnostic impression that there's no evidence of  
10 acute osseous fractures or disruptions related to  
11 the accident.

12 Did I read that correctly?

13 A. Yes.

14 Q. Now, Dr. Higginbotham never said any of these  
15 conditions that were found were related to the  
16 automobile accident in his reports, did he?

17 A. Let me see the rest of it. Well, he goes on to  
18 say at the top of Page 5 he talks about the MRI  
19 findings we discussed.

20 Q. Yes, sir.

21 A. He says, "From a medical perspective, however, it  
22 does not appear to be likely or probable that  
23 these changes are related to the auto [sic]  
24 accident" so from his standpoint maybe he was  
25 saying the epidurals -- I would disagree -- but



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1 the epidurals could be tried just because  
2 because, but he did not think those changes were  
3 related.

4 Q. To the automobile accident?

5 A. Right.

6 Q. Thank you. Lastly, I want to show you Exhibit 7  
7 and ask you if Dr. Endress -- I'm sorry.

8 In the last paragraph on the third  
9 report from Dr. Endress, what if any findings did  
10 Dr. Endress suggest relative to the bone scan  
11 that indicated fractures?

12 A. He said it showed no evidence of acute fracture  
13 shoulders, ribs or spine.

14 Q. Was there any designation by Dr. Endress in his  
15 report that any of these conditions arose from  
16 the automobile accident?

17 A. Let's see if they ask about causation. I don't  
18 see -- well, you can infer from his answer to  
19 Question 3 that I was asked about before that he  
20 thinks at least something was related because  
21 Answer 3 was has he reached -- has he,  
22 Mr. Waskowski, reached pre-injury status and his  
23 answer was no, he doesn't think he has, so that  
24 tells me he was thinking that something did  
25 happen and he hadn't yet come back to baseline.

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1 Q. Does that report tell you what it was that he  
2 thought had happened?

3 A. No -- well, I'm sorry, in terms of what he meant  
4 by Number 3 --

5 Q. Right.

6 A. -- Number 2 said -- Dr. Endress' answer was about  
7 the disk herniations in the neck and low back.

8 Q. Having reviewed those reports again with  
9 Mr. Temrowski, with myself and in your initial  
10 view, does that -- does any of this change any of  
11 your opinions relative to your ultimate diagnosis  
12 of malingering for Mr. Waskowski?

13 A. No, primarily because the main line of  
14 questioning was about disk herniation and, again,  
15 disk herniation takes on a very specific clinical  
16 pattern and there's nothing in any of --  
17 certainly my exam or any other documentation by  
18 anybody else that would suggest disk herniation  
19 and those changes are chronic degenerative  
20 changes found on MRI, they're not acute.

21 MR. HEWSON: Thank you, sir. I have  
22 nothing else.

23 RE-EXAMINATION

24 BY MR. TEMROWSKI:

25 Q. I just want to clarify one thing, doctor. These

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1 reports from Dr. Donahue that we've talked about  
2 and had marked as Exhibit 4, if my client is  
3 Mr. Waskowski and Mr. Waskowski treated with a  
4 doctor such as Dr. Donahue, would you find it  
5 unusual for me as the attorney to write to the  
6 doctor to get a report from the doctor?

7 MR. HEWSON: Objection, relevance. Go  
8 ahead.

9 A. Oh, you're asking about that it was addressed to  
10 you?

11 BY MR. TEMROWSKI:

12 Q. Right.

13 A. No.

14 Q. You don't see anything unusual about that, do  
15 you?

16 A. We're in the system obviously and so -- no, I  
17 don't see anything unusual.

18 Q. And I just want to clarify one other little thing  
19 here. Dr. Donahue's first report on  
20 Mr. Waskowski was dated August 19, 2010, right?

21 A. Yes.

22 Q. And he clearly states that on that particular day  
23 he saw Mr. Waskowski as a patient in his office?

24 A. Yes.

25 Q. When you look at the December 14 report that

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1 Dr. Donahue wrote to me, does he -- does the  
2 doctor indicate anywhere in there that he  
3 actually saw Mr. Waskowski on December 14?

4 A. So you think this might just be a summary of  
5 his --

6 Q. Correct.

7 A. -- of his input so far to that date? Which would  
8 explain why the report was identical from one to  
9 the other.

10 Q. Exactly.

11 A. Yeah, it could be. He doesn't say so though and  
12 usually -- I mean, I've seen a lot of reports  
13 like this and usually it would be that this is a  
14 summary of my exam from this and such date. He  
15 didn't mention the 8-19-10 date whatsoever in  
16 here.

17 He says spine questionnaire 8-19-10,  
18 so if that's the case, if it was only the one  
19 examination, then -- and he's just recounting  
20 what happened before, then I'll take back my  
21 concern about the reports being verbatim from one  
22 to the other.

23 Q. And last but not least regarding whether or not  
24 Dr. Donahue is board certified, would we -- since  
25 we're at your office here today -- would we be

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1           able -- because you said it would only take a  
2           second -- could we go off the record and you  
3           check that?

4    A.    I'm not online here in the office, believe it or  
5           not.

6    Q.    Well, let me ask you this then, doctor.  If  
7           Dr. Donahue performed surgery at William Beaumont  
8           Hospital, would you expect him to be board  
9           certified?

10                   MR. HEWSON:  Objection, foundation.  
11           We're not going to hear from Dr. Donahue.  
12           Subject to that, you can answer, please.

13   A.    Not necessarily.  I mean most medical centers  
14           have standards of, you know, what they want  
15           someone to be.  Some will say you have to be  
16           board certified, but I don't know what Beaumont  
17           standards are for privileges.

18   BY MR. TEMROWSKI:

19   Q.    So when Mr. Hewson asked you questions about  
20           whether or not Dr. Donahue is board certified or  
21           Dr. Glowacki or Dr. Zamorano, you don't need to  
22           be, do you?

23   A.    No, you don't need to --

24   Q.    In order to practice.

25   A.    You don't need to be board certified to practice

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1 medicine, no. You need to be licensed, but not  
2 board certified.

3 Q. Right, and as you just stated, you don't -- some  
4 hospitals don't require that you be board  
5 certified to do surgery there, correct?

6 A. Right.

7 MR. TEMROWSKI: Thank you, I have  
8 nothing else.

9 RE-EXAMINATION (CONTINUED)

10 BY MR. HEWSON:

11 Q. Without board certification, there's no  
12 evaluation of the doctor by their peers as to  
13 their skill level, is that true?

14 A. That's correct.

15 MR. HEWSON: Thank you. I have nothing  
16 else.

17 MR. TEMROWSKI: No questions.

18 VIDEOGRAPHER: This concludes the  
19 deposition and we're going off the record at  
20 2:47 PM.

21 (The deposition was concluded at 2:47 p.m.,  
22 signature of the witness was not requested by  
23 counsel for the respective parties hereto)

24

25

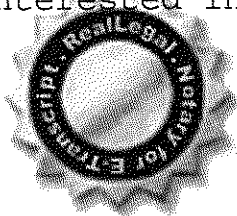
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CERTIFICATE OF NOTARY

STATE OF MICHIGAN )  
 ) SS  
COUNTY OF WAYNE )

I, DALE E. ROSE, Certified Shorthand Reporter, a Notary Public in and for the above county and state, do hereby certify that the above deposition was taken before me at the time and place hereinbefore set forth; that the witness was by me first duly sworn to testify to the truth, and nothing but the truth, that the foregoing questions asked and answers made by the witness were duly recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to either party nor interested in the event of this cause.



A handwritten signature of Dale E. Rose in black ink, written over a horizontal line.

DALE E. ROSE CSR-0087  
Notary Public,  
Wayne County, Michigan

My Commission expires: 7-15-18

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